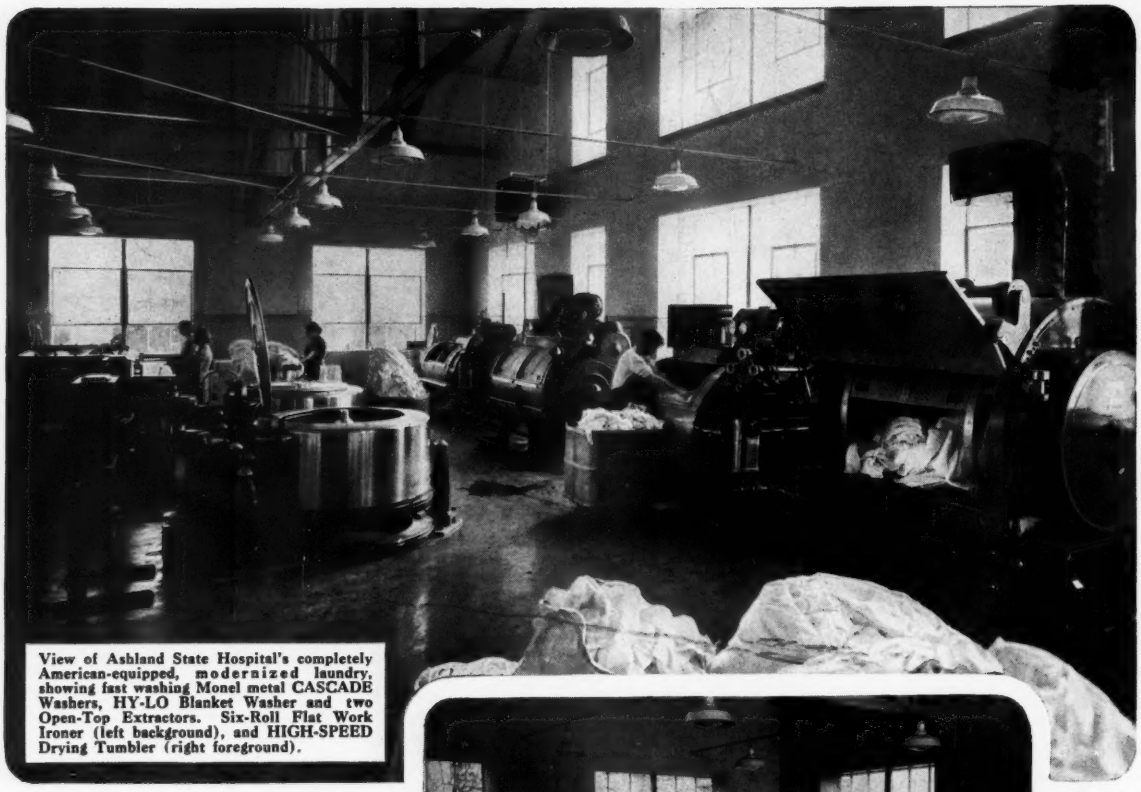
TORONTO, JUNE, 1943

# THE CANADIAN HOSPITAL

· OFFICIAL JOURNAL · CANADIAN HOSPITAL COUNCIL ·



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"The Canadian Hospital"
**Official Journal of the**
**Canadian Hospital Council**

Vol. 20 JUNE, 1943 No. 6

## CONTENTS



CCAB

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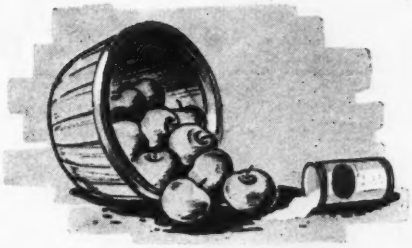

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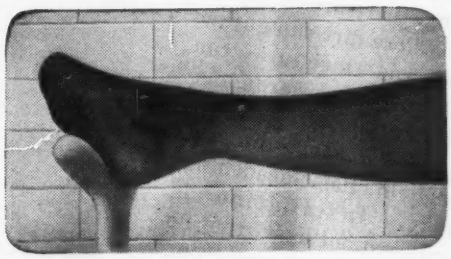
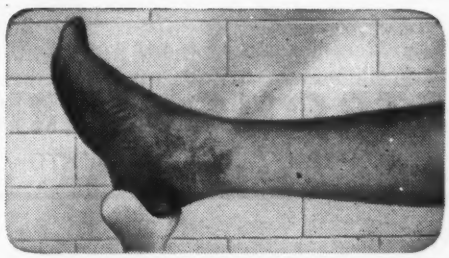


*Condition of Leg, 24th January.*



*Condition of Leg, 7th March.*

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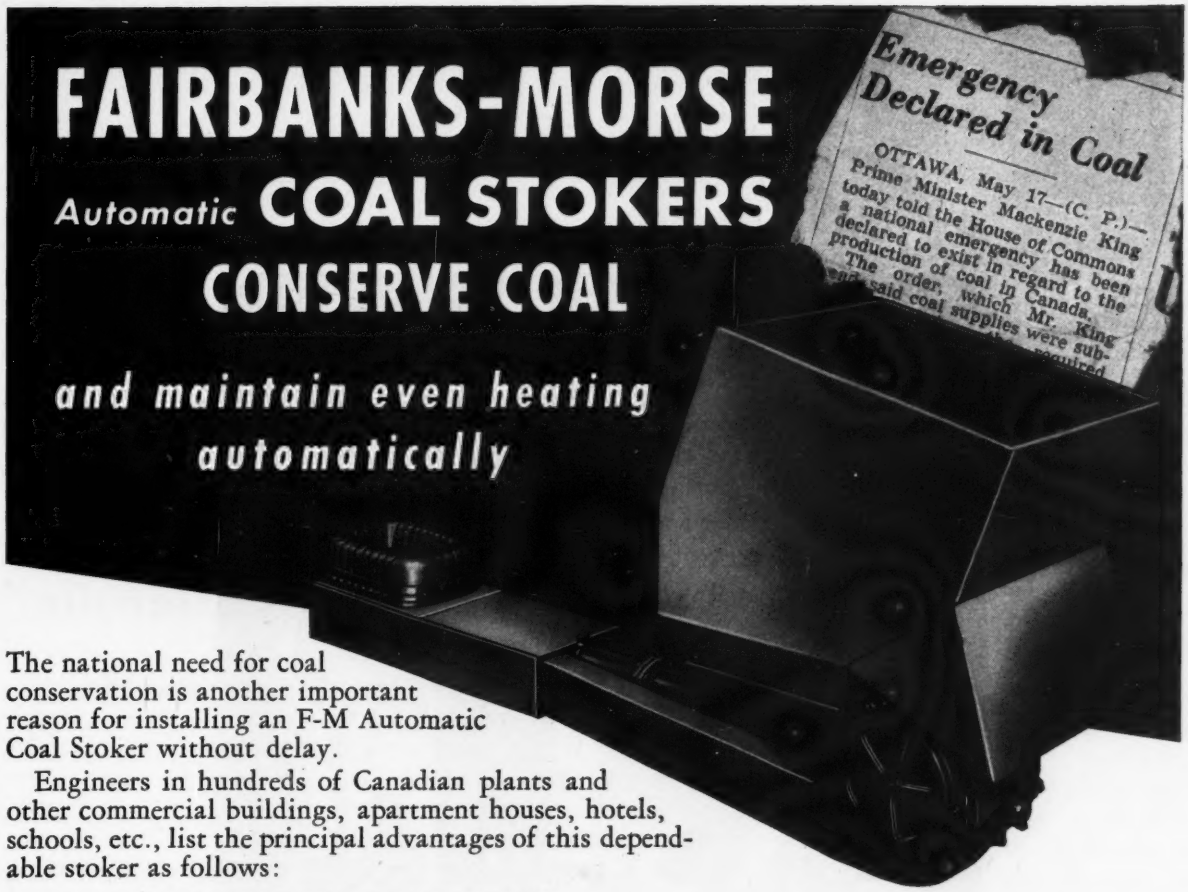


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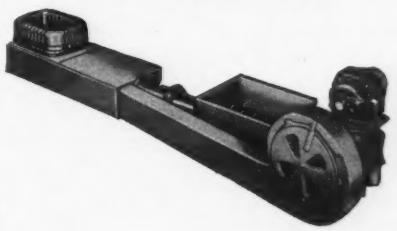

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(1) 1939, Food and Life; Yearbook of Agriculture
U. S. Dept. Agriculture, U. S. Gov't.
Printing Office, Washington, D. C.
1938, J. Am. Med Assn 110, 650
1940, J. Am. Dietet. Assn. 16, 891

Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, June, 1943 Vol. 20 No. 6

Informative Conference at Ottawa

# National Health Survey Provides Composite Picture of Canada's Present and Future Needs

THE finest review of Canada's health facilities ever assembled was presented at the meeting of the National Health Survey Committee at Ottawa on April 30th. Over fifty men and women representing the various organizations participating were in attendance to present and discuss the different summaries and analyses. The Conference was under the direction of Brigadier Jonathan C. Meakins, Deputy Director Medical Services and acting-Chairman, Canadian Medical Procurement and Assignment Board, who presided, and Dr. T. C. Routley, the C.M.P.A.B. Secretary.

Survey summaries were presented dealing with: The Armed Forces (Dr. A. E. Archer); nursing (Miss K. W. Ellis); public health (Dr. J. J. Heagerty); dentistry (Dr. Don Gullett); hospitals (Dr. Harvey Agnew); industry (Dr. Grant Cunningham); research (Dr. J. B. Collip); medical schools (Brig. J. C. Meakins); and the medical profession in each military district from coast to coast. These latter analyses were presented by the respective Divisional Advisory Committees (C.M.P.A.B.) and the twelve field secretaries loaned by the three armed services for these studies.

In many respects this was without doubt the most complete and practical review of the nation's resources for combatting disease ever assembled as one composite picture. From rural practice to health oversight in industry, from dental care to nursing education, from tuberculosis to psychiatry, from research to hospital clinics—the available personnel and facilities from coast to coast were presented for discussion by the spokesmen for the respective groups. While not all of the reports could be presented in final form, they were sufficiently complete to provide reasonably complete summaries of the respective reports shortly to be led in extenso.

### Hospitals

The hospital survey will be reviewed at greater length in these columns when the final report will have been prepared. Suffice it for the present to state that from the partial returns in hand it would appear that the actual bed increase in civilian (general) hospitals since the war began has been 10.9 per cent. The average increase in census has been 21.6 per cent., Nova Scotia leading with 42.2 per cent.

Full-time personnel has increased 15.4 per cent. and part-time personnel 56.8 per cent. There has been an increase of 20 per cent. in general duty nurses and 15 per cent. in supervisors and head nurses. Office staffs have gone up 20 per cent., presumably, said one report, to fill in government forms and to collect coupons. Hospitals report being definitely understaffed, for the work has become more intensified and many of the staff less competent.

Additional patients could be admitted in case of emergency, but not nearly as many as reported in the previous survey in December, 1940. Enlisted doctors and nurses could be utilized in some but not in all hospitals. Personnel and facilities could be shared by some hospitals but not by many, owing to heavy demands at the present time. A fair number of hospitals could accept military patients, some 118 being able to provide a separate ward if necessary.

The second portion of the hospital report dealt with "Post-War Hospitalization". This will be reviewed

at greater length in a subsequent issue.

### Medical Facilities

The medical and dental reports were the most exhaustive, covering as they did replies from nearly every physician and dentist in the country. Some of the field secretaries had personally visited almost every doctor in their districts. The repeated conclusion was that very few doctors in rural areas could now be spared for military service. In New Brunswick, excluding institutional doctors, there is now but one doctor to each 3,465 of population. In the Magdaleine Islands the ratio is 1 to 8,000. In Manitoba the ratio is 1 to 1,884; forty-one municipalities have no doctor and of the doctors in rural areas some 65 per cent. are over 40 years of age. In Saskatchewan no doctors are available; doctors are urgently needed in 10 areas and could be placed in 70 places. A limited number of doctors could be spared, mostly from the larger centres.

From all parts of Canada came recommendations that doctors be "frozen" for the duration. Some of the regional committees recommended that power be given to permit moving of doctors to areas needing medical care. One committee recommended that the call-up age for all doctors be raised to 45, and that doctors in "E" category be made assignable to needy areas. The valiant efforts of rural doctors, many of whom are mature in years, to carry on was warmly praised. The shortage, too, it was pointed out, was no greater than had existed in pre-war days. In one British Columbia rural area, a ratio of 1-3,300 was not too onerous because the people had been educated to consider the doctor's time and to visit their offices whenever possible.

Mr. Westman of National Selective Service discussed ways and means whereby members of the medical profession could be "frozen," should such action be deemed necessary.

### Public Health

The situation in the public health field is quite serious, stated Dr. Heagerty. Public health staffs are now depleted to a subminimal degree. Practically every mental hospital in the country has an inadequate staff. War replacements are not as well skilled in the handling of mental patients. The personnel ratio is lowest in British Columbia.

Serious reductions have been made in the staffs of tuberculosis sanatoria and clinics. Here, too, it may be necessary to freeze personnel. No full-time personnel should be taken without the consent of the provincial officer of health.

### Nursing

The survey has revealed a total of 26,268 registered nurses, the highest number per thousand being in British Columbia (3.48), followed by Ontario (3.29) and Manitoba (2.31). Some 1,296 religious sisters are included. General hospitals with schools report 3,851 registered nurses employed and 8,266 students. Other hospitals report 2,180 registered nurses employed. These are increases. On the other hand mental hospitals show a drop in registered graduates from 1,073 to 794. Sanatoria reported a drop from 677 to 538. There are 1,188 official public health nurses and 923 doing voluntary public health. Some 719 are in industry and 65 with the T.C.A. Some 2,008 are enlisted with the armed forces.

Schools reporting most difficulty in obtaining students are those in hospitals averaging less than one hundred patients (66.6 per cent. of the latter group as compared to 44.7 per cent. of those connected with larger hospitals). Forty per cent. of general staff nurses in general hospitals and thirty-one per cent. of those in sanatoria receive under $850 per annum.

In general hospitals hours for general staff nurses range from as high as 160 hours per fortnight to the recognized 96-hour fortnight. Fifteen per cent. are working over 121 hours a fortnight. Student nurses range from 96 to 140 hours per fortnight, the latter indicating night duty. In some cases classes are included in these figures and in others not so. (The C.N.A. has recommended that student nurses be on a 96-hour fortnight including class periods, that hours of night duty be not greater than those of day duty and that there be one whole day off each fortnight.)

The augmented programme of graduate education was reviewed, as were also the steps taken by the C.N.A. to augment enrolment of students of the right type. The growth of the nurse aide movement was noted. Although no provision has been made for the licensing of auxiliary nursing groups, 17 out of 26 professoinal registries in Canada now include these groups. Mention was made of the programme to utilize married nurses and to obtain the support of private duty nurses to meet emergencies in hospital or elsewhere, to reduce rest intervals between cases and to accept a wider range of patients.

Only two schools so far have adopted the accelerated course. This has been approved by the C.N.A. with certain reservations, for it is recognized that only certain carefully-selected schools can undertake these courses with safety.

### Industrial Medicine

Much progress has been made in the provision of medical and nursing oversight for industrial employees. However, there are still too many plants with inadequate health supervision. There should be one hour per week of medical attendance for every 100 employees with a full-time doctor for every 3,000 employees. There should also be one nurse for every 500 employees. The number of full-time and part-time doctors under 35 years was reported. One of the problems is to replace these younger men by older men without disrupting the organization already set up.

It is estimated that it would require 241 additional doctors and 1,000 nurses to provide industry with adequate health supervision.

### Research

Under the National Research Council medical research, both military and civilian, is being actively carried on. For military reasons some of the more important studies cannot be discussed at this time.

### Dental Survey

The study by the Canadian Dental Association was particularly complete. This profession is finding it extremely difficult to meet both mili-

*(Concluded on page 52)*

# A Brief on Cancer Control

**Presented to the Special Committee on Social Security of the House of Commons by the Executive Committee of the Department of Cancer Control of the Canadian Medical Association.**

WM. BOYD, M.D., F.R.C.P., F.R.S.C., Chairman

CANCER has become one of the most important of the killing diseases, being surpassed in this respect only by heart disease. The great fall in the general death rate which has taken place during the present century is due very largely to mastery of the infectious diseases caused by bacteria. Cancer, on the other hand, presents one of the main unsolved problems which confront medical science. The disease is often accompanied by long periods of suffering and disability. The efforts of medical sceince are being directed with considerable success to improving the methods of diagnosis and treatment. An immense amount of research is being conducted on the profoundly difficult problems of the cause and the nature of the disease. For these reasons, the subject of cancer demands consideration in any scheme dealing with Health Insurance.

### Cancer on the Increase

The death rate from cancer has been steadily rising. In the year 1926 this rate was 81 per 100,000 population in Canada; in 1941 it had reached 117. At the present time there are at least 50,000 cases of cancer in Canada, and about 13,000 deaths from the disease every year. Out of every ten adults, one will probably die of cancer. The actual figure may well be considerably higher, for in large hospitals post-mortem examinations reveal that many patients have suffered from cancer which was undiagnosed during life. Some of the increase, which has been observed in all parts of the world, is probably due to better methods of diagnosis and also to the fact that a larger percentage of the population is reaching a more mature age, for cancer is pre-eminently a disease of advancing years. Thus the death rate is highest in Nova Scotia (135.6 in 1940) and in British Columbia (147.5), provinces in which the age composition is the highest. Part of the increase, however, appears to be real, although no satisfactory explanation for this can be given.

### Cancer Control

The term cancer control, although in general use, is somewhat misleading. The disease cannot be controlled in the sense that smallpox, tuberculosis, and vitamin-deficiencies can be controlled. Control implies prevention, and prevention is only possible when the case and nature of a disease are understood. But the control of diagnosis and treatment is possible, and marked improvement in results has followed the organization of such control. The two basic requirements for this type of control are *early diagnosis and early treatment.*

### Methods of Treatment

Cancer is at first a local disease and, while it is still local and accessible, it is curable. Unfortunately by the time the disease is recognized it may no longer be localized. This delay in diagnosis is in part due to the doctor, who may not suspect that cancer is the cause of the symptoms of which the patient complains, and in part to the patient, who is unaware of the significance of his or her symptoms, or, being wrongly convinced of the hopelessness of the disease, is afraid to consult a doctor. Delay in treatment may be due to the expense of transportation to a treatment centre, or to reluctance on the part of the patient to give up work for a lengthy course of treatment for a lesion or pathological change which may appear to him to be trivial and insignificant. An adequate follow-up system is essential, not only to determine the results of treatment, but also to detect at the earliest moment any recurrence of the disease for which further treatment may be necessary.

At the present time there are only two recognized methods of dealing with the disease. The tumour may be removed *surgically* or it may be treated by means of *radiation,* the latter including radium and x-rays. Both methods demand for their success a high degree of specialization. This is true both of the radiologist and the surgeon.

*Specialized treatment can best be provided in cancer centres or cancer clinics.* These centres will usually be developed in connection with existing hospital facilities, but separate institutions may be established, depending on local conditions which will vary widely. In these centres the most efficient forms of treatment and diagnosis are made available. They serve also as centres for the dissemination of knowledge regarding the disease, and it is here that advances are likely to be made in developing new methods of treatment.

### General Principles of Organization

The Department of Cancer Control of the Canadian Medical Association, through its Executive Committee and in consultation with representatives in the various provinces, has given careful study to the question of cancer. As a result of this study the Committee begs to suggest that the following general principles of organization should be considered:

1. The diagnosis and treatment of cancer should be included under the Health Insurance section of the National Health Act rather than under the Public Health section;

2. The Health Insurance Section of the Act and/or the First Schedule of the Dominion Act pertinent thereto, should provide for the diagnosis and treatment of cancer and research on cancer to be sponsored by the Federal Government jointly with the Provincial Governments, together with the Provincial Medical Associations, the Medical Faculties of the Universities, and such Hospitals and Treatment Centres as may be concerned. It may be considered advisable to set up a Federal organization in addition to the Provincial organizations recommended below. If such an organization were established, it should include representation from the National Research Council;

3. Cancer is a disease whose proper management requires centralization of diagnosis and treatment;

*(Continued on page 54)*


# National Nutrition Programme

## makes satisfactory progress

**By L. B. PETT, Ph.D., M.D.,**
**Director of Nutrition Services,**
**Department of Pensions and National Health**

THE task of Nutrition Services during the past year has been to organize the Canadian Nutrition Programme on no less than four fronts: One front is concerned with workers in war industries, to see how well fed they are; the second big front is to co-ordinate into a uniform battle line all the agencies that are concerned with nutrition, whether provincial, civic or voluntary, so that the public may be informed on fundamentals of nutrition; the third front has been concerned with advice on nutrition to other governmental bodies, because it is clear that consumer education is not enough, without other official assistance; the fourth front has been in the field of nutritional research, chiefly analytical figures of foods in Canada, and surveys among various groups of people. Advice is sought from the Canadian Council on Nutrition and from many other sources.

### Industry

Considerable progress has been made on the industrial front. We knew how most of Canada's war workers are fed in the plant, as a result of inspections in a sample of over 300 different industries. Advice has been given leading to definite improvement, and much information on how to eat for health has been given to hundreds of thousands of war workers. Of 116 cafeterias with which we have contact, many were started in the last year. I hope that some day every industry, regardless of size, will concern itself with the food eaten by the worker in the plant, and will also take an interest in meals at home. Such an interest will be for the industry's own good as well as for the good of its employees.

### Education

A little progress has been made on the educational front. Certainly there are today nurition programmes going on in about eighty different communities, while two years ago there were only about seven such campaigns in all Canada. We have had magnificent support recently from many advertisers, magazines and newspapers in making people conscious of nutrition. But it is still not beginning to reach all Canadians. There are still many problems to be

*Above: "Thumbs down" on a chocolate bar and a coke for lunch. War workers need nutritious and balanced meals. Below: The Cafeteria of the de Haviland Plant.*

*The "K" Club experiment by the Kiwanis Club of Toronto gave striking proof of the value of providing improved nutrition for school children. In twelve weeks the children averaged a gain of 3.05 pounds. The meals were directed by Miss Winifred Moyle, dietitian (second from right) and Miss Mary Floyd, R.N. (far right.) Dr. H. M. Harrison was chairman of the health committee.*

solved, concerned with provincial rights, and unco-operative groups, and local indifference, and other factors.

In the future I hope that this educational front will broaden in several specific ways:

(1) There should be properly-trained nutritionists connected with all welfare groups.

(2) Public health departments need a nutritionist, too, and again such help is still rather rare in Canada. Obviously each province needs an official to co-ordinate this work, and there is very definite need for leadership and assistance in nutrition from the federal nutrition services. Only in this way will it be possible to keep up this work all year round.

It must be said here that there will always be a need for the impetus and assistance of local voluntary associations and people. No welfare group, nor health department, can be left alone with such an important job.

(3) Nutritional education must be developed in the schools. I think that the school lunch could make the greatest contribution to health of any single development in the field of nutrition. It is not unreasonable to hope that an adequate school lunch programme throughout Canada would make remarkable changes, especially among apparently slow or backward children. They would learn faster and be happier.

**Research**

On the advisory front and the research front something has been accomplished, mostly in small details that cannot be covered here. An effort is being made to co-ordinate the whole picture with the Canadian Nutrition Programme.

While it is too early to indicate the full accomplishment, there is no doubt that a real advance has been made on all four fronts.

**Fundamental Aim**

In all this dicussion one aim is apparent. There should be a time some day when it will be difficult for a person not to be well fed. This means an improvement in the economic status of many people, because we must admit that many people cannot afford an adequate diet. I belive that other measures will do as much good as improved economic status. Many people are indifferent to all our efforts, and even with extra money would not get the foods needed for adequate nutrition. We must make it difficult for them to get anything but the right foods.

How is this aim to be achieved? What is needed to make it difficult for a person to be poorly fed?

This goal means much more than improved economic conditions, and much more than consumer education —although both of these are essential. It means adequate production of the proper foods—something that calculations show has never yet existed in Canada. In order to get that agricultural production there must be economic incentives such as guaranteed prices, subsidies and farm loans.

Having produced the right foods in adequate amounts there must be a nutritional standard for food storage and for food processing, so that what has been produced may not be lost. This will mean changes in the technological side of food industries. There will also be a new basis for the Food and Drugs Act, not just protecting the public from proved harm, but promoting positive health by higher standards.

Production and storage and processing on a nutritional basis would be a great achievement, but there would remain a big job to be done in distribution. Regardless of economic improvement there will be groups who need extra help in getting the foods they need. Expectant mothers and young children, invalids and welfare charges all come in this category. We should recognize their right to certain foodstuffs and help them to obtain such foods. Furthermore, special allotments of foods for school lunches and for industrial workers would aid in the development of these important steps towards our goal of adequate nutrition for all.

This is our goal for nutrition in Canada: the hope that proper foods may be adequately produced, under an assured income, carefully stored and processed, equitably distributed and properly consumed. We are a long way from this goal, and I do not know when we shall reach it. But I do believe that nutrition applied in this way should mean an amazing saving of money and lessening of misery in the reduction of the great burden of poor health, sickness, loss of work, bad teeth, etc., which is now found throughout Canada and the world.

# Mémorandum re Assurance-Maladie

**Présenté au Comité Spécial de Sécurité Sociale de la Chambre des Communes par le Canadian Hospital Council, le 9 avril, 1943**

M. le Président, M. Mackenzie, Mme Casselman, Messieurs:

Le Conseil des Hôpitaux Canadiens apprécie hautement cette occasion qui lui est donnée de se faire entendre devant le Comité Spécial de Sécurité Sociale de la Chambre des Communes. En principe, les hôpitaux existent pour rétablir la santé du peuple. Or, toute mesure qui serait adoptée, touchant le soin des malades, affecterait profondément le travail humanitaire de nos hôpitaux. Il est donc tout à fait naturel que ceux-ci soient grandement intéressés au projet actuel de législation.

## Le Conseil des Hôpitaux Canadiens

Le Conseil des Hôpitaux Canadiens est une fédération des associations provinciales, inter-provinciales et régionales des hôpitaux du Canada; il comprend, en tout, douze associations. Outre les associations provinciales et l'Association des Hôpitaux des Provinces Maritimes, le Conseil groupe les conférences régionales de l'Association des Hôpitaux Catholiques des Etats-Unis et du Canada. Dans la province de Québec, il n'y a pas d'association provinciale des hôpitaux: le Conseil des Hôpitaux de Montréal et les Conférences de l'Association des Hôpitaux Catholiques de Montréal et de Québec représentent les hôpitaux auprès du Conseil des Hôpitaux Canadiens. Sont aussi membres du Conseil: le Comité du Service d'hospitalisation de la "Canadian Medical Association", ainsi que le Ministère des Pensions et de la Santé Nationale et le Service ou Ministère de la Santé de chacun des gouvernements provinciaux. Bien que la collaboration de ces organismes publics soit fort appréciable, ils n'adhèrent au Conseil des Hôpitaux Canadiens qu'à titre de membres associés et, comme tels, n'ont aucun apport officiel dans ce mémoire. En effet, pour ne pas gêner les décisions du Conseil et conserver leur propre liberté, leurs représentants déclinent tout droit de vote.

En résumé, le Conseil des Hôpitaux Canadiens représente individuellement les hôpitaux par l'intermédiaire de leurs associations respectives et conférences. A quelques exceptions près, les hôpitaux à charte indépendante, les hôpitaux municipaux et les sanatoriums antituberculeux appartiennent tous à ces associations et conférences.

### Le Système des Hôpitaux du Canada

On se saurait rattacher le système des hôpitaux du Canada à un type défini. Le premier hôpital, tant du Canada que des Etats-Unis, l'Hôtel-Dieu de Québec, fut fondé il y a plus de trois cents ans, en 1639. Cette fondation et d'autres semblables qui suivirent relevaient d'ordres religieux. Ce n'est que plus tard que les hôpitaux fondés et dirigés par des associations laïques devinrent plus nombreux. Ces dernières années, le type d'hôpital dit: Municipal, Civique ou d'Union, a pris beaucoup d'extension, surtout dans les Provinces des Prairies de l'Ouest.

Voici, d'après les chiffres relevés en 1941 par l'Office fédéral de la Statistique, un tableau comparatif des types divers d'hôpitaux canadiens:

**Hôpitaux du Canada, 1941**

| | Hôpitaux | Lits pour adultes et lits pour enfants | Bassinettes |
|---|---|---|---|
| Maladies aiguës[1] | 573 | 46,504 | 5,980 |
| Tuberculose | 43 | 10,992[2] | ..... |
| Maladies chroniques et maladies incurables | 20 | 3,415 | ..... |
| Maladies contagieuses | 14 | 1,713 | 5 |
| Hôpitaux publics pour convalescents | 10 | 830 | ..... |
| Maladies mentales | 60 | 40,115[3] | ..... |
| Hôpitaux privés | 325 | 3,867 | 776 |
| Hôpitaux du Dominion[4] | 175 | 9,493 | 6 |
| TOTAL | 1,220 | 119,019 | 6,766 |

**Personnel des Hôpitaux du Canada en 1941**

A. **Maladies aiguës et chroniques** (autres que la tuberculose)—

| | Hôpitaux | Lits pour adultes et lits pour enfants | Bassinettes |
|---|---|---|---|
| A CHARTE INDEPENDANT[5] | | | |
| Laïques | 215 | 20,106 | 2,478 |
| Catholiques romains | 181 | 21,886 | 1,593 |
| Red Cross et Junior Red Cross | 44 | 590 | 160 |
| United Church | 19 | 546 | 103 |
| Salvation Army | 11 | 688 | 295 |
| Anglican Church | 6 | 211 | 19 |
| Autres | 17 | 733 | 92 |
| HOPITAUX MUNICIPAUX (Y compris les hôpitaux dits d'Union) | 120 | 8,842 | 1,213 |

(1) Comprend les hôpitaux Généraux, pour les femmes, pour les enfants et les hôpitaux non classifiés.

(2) Comprend 2,090 lits en 37 sanatoriums pour tuberculeux et hôpitaux pour maladies aiguës.

(3) Comprend 785 lits de deux hôpitaux du Dominion.

(4) Statistiques du 24 septembre 1940.

(5) Y compris les hôpitaux généraux, pour les enfants, pour les femmes, pour maladies aiguës, pour convalescents, pour incurables, les hôpitaux de la Croix Rouge et les non classifiés.

| | | | |
|---|---|---|---|
| HOPITAUX PROVINCIAUX ..... | 4 | 950 | 31 |
| HOPITAUX FEDERAUX ..... | 175 | 9,493 | 6 |
| HOPITAUX PRIVES (Y compris les hôpitaux d'usines industrielles) | 325 | 3,867 | 776 |
| TOTAL ..... | 1,117 | 67,912 | 6,766 |
| B. **Sanatoriums antituberculeux** ..... | 43 | 8,902 | ..... |
| Laïques ..... | 24 | 5,887 | ..... |
| Catholiques romains ..... | 5 | 754 | ..... |
| Provinciaux ..... | 6 | 1,358 | ..... |
| Municipaux ..... | 4 | 656 | ..... |
| Fédéraux[1] ..... | 4 | 247 | ..... |
| Annexes pour tuberculeux dans les hôpitaux pour maladies aiguës[2] | 37 | 2,090 | ..... |

On voit, par ces tableaux, que notre système hospitalier est une combinaison de types d'hôpitaux divers et nombreux. Il semblerait juste, cependant, de le ranger sous un seul chef: celui des hôpitaux à charte indépendante, sans but lucratif.

### Appréciation du Système

Le système d'hôpitaux, tel qu'il existe au Canada, a ses bons et ses mauvais côtés. Dans l'ensemble, cependant, nous croyons que les Canadiens ont le droit de se montrer fiers de leurs hôpitaux qui valent bien, d'égal à égal, ceux de n'importe quelle partie de l'univers et qui sont d'emblée supérieurs à ceux de plusieurs autres pays.

## Avantages du système

**1. Dispersion des hôpitaux sur le territoire canadien.**

La population canadienne est dispersée sur toute l'immense étendue de son territoire; ainsi en est-il des hôpitaux qui se trouvent, de ce fait, accessibles à tous les citoyens. De petits hôpitaux se dressent dans tous les milieux où la population est assez nombreuse pour suffir à leur entretien. Environ 54 pour cent de nos hôpitaux publics généraux ont une capacité de 50 lits ou moins. Environ 25 pour cent ont une capacité de 25 lits ou moins. La première guerre mondiale amena chez nous un regain d'activité dans la construction des petits hôpitaux, regain qui se manifesta, particulièrement dans les provinces du centre, la Colombie-Britannique et les Provinces Maritimes, par la création des hôpitaux dits "Memorial". Plus tard, la tendance vers l'hôpital civique ou municipal envahit les districts ruraux, surtout les Provinces des Prairies où les municipalités rurales popularisèrent le type dit "Union Hospital". Plusieurs districts ruraux qui ne possèdent pas d'hôpitaux publics sont desservis par de petits hôpitaux privés.

Et là où la population n'eut pas les moyens d'entretenir un hôpital, la Société Canadienne de la Croix Rouge bâtit et administra de petits hôpitaux ou maisons de santé qu'elle remit plus tard à la population, lorsque celle-ci pût en prendre la responsabilité. Il y a actuellement 44 unités d'hospitalisation de la Croix Rouge, dispersées, depuis l'île Grand Manan, sur l'Atlantique, jusqu'à Kyuquot, en Colombie Britannique.

**2. Les hôpitaux ont grand soin des pauvres.**

Les malades indigents, qui ne peuvent acquitter leurs frais d'hospitalisation, ont tout de même accès à l'hôpital, où ils reçoivent tous les soins requis. Nos hôpitaux accueillent tous les patients, indépendamment de leur fortune, de leur nationalité, de leur religion ou de leur race.

**3. Les allocations des provinces et les paiements des municipalités sont d'un grand secours aux hôpitaux.**

Le système actual de paiements, effectués par les municipalités pour frais d'hospitalisation de leurs indigents, et des sommes allouées par les gouvernements provinciaux, pour chaque jour d'hospitalisation de certaines catégories de patients (ceux des salles publiques, dans certaines provinces; tous les patients, dans d'autres provinces) est spécial à notre pays. Quelques états seulement de la république voisine ont adopté ce système, et très peu d'autres systèmes lui sont tout à fait identiques. Les paiements sont généralement inférieurs au coût d'hospitalisation, mais ils permettent aux hôpitaux de donner aux patients nécessiteux les bons soins que ceux-ci reçoivent actuellement. Non seulement a-t-on atteint ces résultats, mais plusieurs jeunes municipalités à revenus limités ont déjà été dotées d'un hôpital par leurs citoyens, encouragés par ce fait qu'une grande partie du coût d'hospitalisation des patients nécessiteux serait défrayée, grâce à ce système. Cet encouragement à l'effort volontaire est d'une grande importance vu que très peu d'hôpitaux jouissent de dotations substantielles.

**4. La plupart de nos hôpitaux sont publics: il y a peu d'hôpitaux privés.**

Environ 67 pour cent de nos hôpitaux pour maladies aiguës ou pour maladies chroniques (autres que les hôpitaux pour maladies mentales et les hôpitaux fédéraux) sont des hôpitaux publics, i.e., n'ayant aucun but lucratif, (qu'ils soient à charte indépendante ou municipaux) et autorisés, par leur gouvernement provincial respectif, à recevoir une assistance municipale et provinciale pour le soin des malades indigents.* Actuellement, 94 pour cent des lits affectés à ces malades se trouvent dans les hôpitaux publics, ce qui multiplie le nombre total de lits dans ces hôpitaux et augmente le coût d'hospitalisation des patients qui ne peuvent payer leurs frais d'hospitalisation ou qui n'en peuvent payer qu'une partie. Enfin, cela permet un contrôle plus effectif du service provincial de la Santé.

**5. Le service se maintient à un haut degré de perfection.**

Il y a plusieurs facteurs qui expliquent l'efficacité de notre service hospitalier:

(a) La surveillance et le contrôle du gouvernement provincial;

(b) le programme de "standardisation" de l'American College of Surgeons qui a servi d'instru-

(1) Y comprise un sanatorium ouvert en 1942.

(2) Ces chiffres sont compris dans Hôpitaux pour maladies aigües.

*Aux Etats-Unis, l'hôpital public est soit municipal, soit gouvernemental. Les hôpitaux à charte indépendante sont souvent appelés "privés". Ce que nous appelons "privés" ici, s'appelle chez nos voisins "à charte particulière".

*C.W.A.C.'s on Parade*

ment et de base dans l'organisation actuelle du travail des hôpitaux;

(c) l'approbation, par l'Association Médicale Canadienne, du mode d'entraînement des internes dans les hôpitaux;

(d) la reconnaissance des écoles de gardes-malades par l'Association des Gardes-Malades provinciales (dans certains cas, avec la coopération du gouvernement provincial), écoles qui ont beaucoup contribué à l'amélioration du service hospitalier.

**6. Les patients d'assistance publique et les patients hospitalisés à leurs propres frais sont dans le même hôpital.**

Tous les hôpitaux à but non lucratif, à charte indépendante ou municipaux, reçoivent des patients d'assistance publique et des cas privés ou semi-privés. Tous ces malades logent habituellement sous le même toît. Parmi ces établissements, il n'y a pas, comme dans plusieurs grandes villes des Etats-Unis, de "county hospitals" réservés aux seuls patients d'assistance publique, ni, comme en Grande Bretagne, d'hôpitaux réservés aux malades payants, ce qui s'appelle "maison de santé", en France.†

Pour tous et chacun, cette conception particulière de l'hôpital est très avantageuse. Elle permet de traiter un plus grand nombre de malades avec de meilleures facilités dont un personnel entraîné pour le diagnostic et le traitement. Le coût d'hospitalisation est réduit, le temps du corps médical épargné, l'atmosphère de la salle publique plus réconfortante et l'esprit démocratique respecté.

## Faiblesses du Système

**1. Les taux d'hospitalisation sont trop élevés pour les patients à petits revenus.**

Le coût d'hospitalisation obère démésurément le budget des familles. Dans les cas de maladies graves ou prolongées, il absorbe souvent toutes les épargnes accumulées péniblement au cours d'une vie. Ce n'est pas que, dans son ensemble, le soût hospitalier soit excessif. Selon l'état de prospérité du pays notre population verse de $22,000,000 à $30,000,000 pour son hospitalisation ce qui ne représente qu'une minime fraction de ce qu'elle dépense pour son tabac, ses liqueurs, ses produits de beauté et les courses. Le mal, c'est que la maladie frappe sans avertir, que le budget familial la prévoit rarement et qu'elle entraine des dépenses d'autant plus onéreuses qu'on est moins en état, à ce moment-là, des les assumer.

Les frais d'hospitalisation sont très bas si on les compare aux résultats, parfois vraiment miraculeux, qu'ils procurent. Ils seraient encore réduits, si les fonds publics couvraient le coût total des soins prodigués aux patient d'assistance publique.

Les assurances-maladies et les fonds de secours qui prévoient les frais d'hospitalisation ont apporté un renfort précieux aux patients dont les revenus sont médiocres. L'un de ces fonds de secours établis en Ontario, "The Plan for Hospital Care", a recueilli, en deux années à peu près, 175,000 adhérents. Plusieurs fonds de secours semblables fonctionnent au pays, disséminés d'un océan à l'autre. Les uns ne prévoient que les frais d'hospitalisation, les autres y ajoutent les frais de médecin. Ces fonds et ces assurances allègent le fardeau économique des hospitalisés et des hôpitaux. Malheureusement, ils sont trop peu répandus, surtout dans les milieux ruraux.

**2. Certains districts ruraux sont dépourvus de facilités hospitalières**

On a loué, plus haut, l'excellence de ces petits hôpitaux dispersés à tous les endroits stratégiques du territoire canadien. Il faut admettre cependant qu'un petit nombre de districts ruraux en sont encore dépourvus. Plusieurs d'entre eux ont besoin d'un hôpital, surtout pendant les mauvaises saisons.

Ce besoin paraît n'être pas aussi pressant qu'il ne l'est en réalité. Grâce aux moyens de communications: bonnes routes, véhicules motorisés, téléphones ruraux et, dans certains cas, avion, la distance ne présente plus les inconvénients d'autrefois. D'autre part, il est avéré qu'un hôpital bien équipé dessert mieux une population que plusieurs petits hôpitaux plus accessibles, mais dépourvus de laboratoire et d'appareils indispensables, comme les rayons X, et insuffisamment équipés de personnel médical et de service hospitalier.

**3. L'insuffisance et le dédoublement résultent du manque de coordination.**

Ici comme dans presque tous les autres pays, aucun plan général de coordination n'a présidé à la fondation de nos hôpitaux. La plupart doivent leur origine et leurs développements à un petit nombre d'hommes et de femmes animés d'esprit civique. C'est pourquoi, en divers milieux, on n'a pas d'hôpital, tandis qu'en d'autres, les aménagements et les services se dédoublent. Ici, on a aménagé trop de lits pour cas privés et trop peu pour les cas d'assistance publique; ailleurs, on a mal pourvu à l'isolement des patients, au soin des convalescents et des malades chroniques.

**4. Le système de paiements pour les indigents est cause de malentendus fréquents entre les hôpitaux et les municipalités.**

La plupart des provinces ont fixé, par décret, le versement quotidien que les municipalités doivent faire aux hôpitaux pour l'hospitalisation de leurs résidents pauvres. En dépit de revisions multiples de ces stipulations, il s'élève encore des controverses interminables sur la signification de "résidents", d' "indigents" et sur l'interprétation qui convient à "versement raisonnable pour chaque jour d'hospitalisation". Pour

*(Suite à page 42)*

†Ces derniers temps, en Angleterre, certains hôpitaux à charte indédendante ont ajouté des lits à l'usage exclusif des patients privés.

*Nursing*

*is attracting*

*our*

*finest young women*

*Photographs by Mrs. Leonard Shaw.*

**BUT**

*we need* **MORE!**

# From Luxury Liner to Hospital Ship

## "Lady Nelson" Serves in New Capacity

THE *LADY NELSON*, former flagship of the Canadian National Steamships' Canada-West Indies fleet, has become the first hospital ship in Canada's history. Her transformation has been complete, with operating room, wards, sterilizers, etc., replacing the luxurious furnishings of pre-war days.

As a passenger ship her accommodation provided for 250 persons; as a floating hospital she has beds for 500—200 up patients and 300 bed cases. Special provision has been made for a few nervous or mental cases.

The ship will be operated by officers and men of Canadian National Steamships, under the command of Captain George W. Welch of Halifax. Her medical complement will consist of nine medical officers, fourteen nursing sisters and 60 other ranks, under Lieut.-Col. A. H. Taylor of Goderich, Ont. Captain Charlotte Nixon of Montreal is Matron.

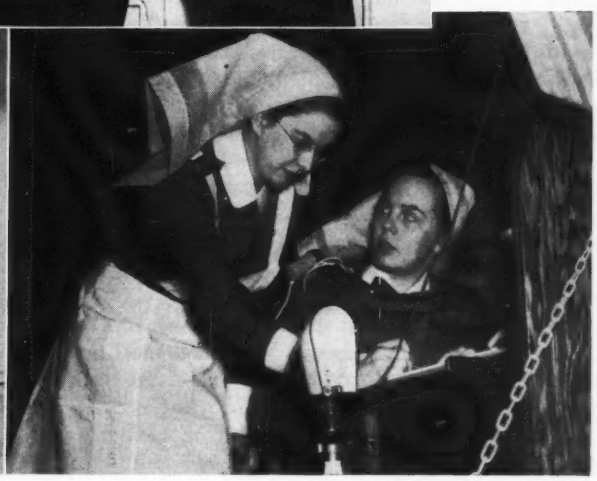
The censorship ban has recently been lifted on the story of the *Lady Nelson's* first encounter with the enemy. While lying at dock at Port Castries in the Caribbean island of St. Lucia last year, she was torpedoed and sunk by a submarine which blasted a hole through the steel protective submarine net across the harbour mouth. The ship was later recovered and towed to a United States port for repairs.

She has now been painted white with a broad green band around her hull, broken at intervals by the distinctive Red Cross. A cross has also been painted on her deck to indicate to airmen that she is a hospital ship. Enemy powers have been advised that she is in service.

"All Canadians of any service will have first call on this new ship, which can be fully outfitted here with stores for a return trip across the Atlantic," said Col. G. A. Winfield, deputy director-general of medical services for the army. In the first years of the war, some Canadian casualties were returned home in British ships chartered by the Canadian government, but the war in the Middle East placed such demands on British ships that they were no longer available. Later Canadians invalided home were transported in returning troop ships, but naturally the accommodation on such vessels was not always suitable for hospital cases.

On May 17th the *Lady Nelson* steamed into port at Halifax after completing her maiden voyage. Her passengers included Canadians invalided home from Britain as the result of accidents, etc., a few Dieppe casualties, and wounded American soldiers from the North African campaign. These latter had been wounded in the early stages of the Allied offensive and had been convalescing in British hospitals before they were embarked on the *Lady Nelson*.

*Above—The former "S.S. Lady Nelson" in battle dress. Left—Nursing Sister Katherine McLean, of Tomstown, receives an order from Major D. W. Stewart of Hamilton.*



*Top—Capt. George W. Welch of Halifax, skipper of the ship, explains the engine-room telegraph to Lieut.-Col. A. H. Taylor of Goderich, officer commanding and Captain Charlotte I. Nixon of Montreal, matron.*

*Left—Members of the ship's surgical staff are shown in the operating room. Left to right, Capt. Alex Ross of Elk Point, Alta., Nursing Sister Evelyn Negus of Truro, N.S., Capt. J. W. Sinclair of Timmins, Ont. and Major A. F. Mavety of Toronto.*

*Right — Nursing Sister Audrey Metzler and Nursing Sister Margaret Dalgleish (wearing Mae West lifebelt) both of Toronto, are deep in discussion.*

*(All photographs courtesy Chief of Information, Armed Services)*

## Canadian Hospital Council to Meet in September

It has been arranged definitely that the Canadian Hospital Council will hold its biennial meeting at the Chateau Laurier in Ottawa on Thursday and Friday, September 9th and 10th. The Executive Committee has decided that the meeting this year will devote the full two days to a discussion of immediate wartime problems, to the National Health Survey recently completed, to health insurance and to the problems of post-war reconstruction as they relate to hospitals. It is anticipated that a number of key individuals in various federal departments will participate in the programme.

Official delegates and others planning to attend should make their hotel and rail reservations well in advance. Correspondence is now being conducted with the various associations with respect to the travelling pool, which it is anticipated will be operative again.

The American Hospital Association will be meeting at Buffalo during the following week, commencing Monday, September 13th. Delegates desiring to go on to Buffalo after the Ottawa meeting (membership in the A.H.A. is not necessary) should make reservations without delay at the Hotel Statler in Buffalo.

# Obiter Dicta

## *Medical Teaching and Health Insurance*

AMONG the many groups likely to be affected by the forthcoming health insurance measure, one which is feeling deep concern over the potentialities of the situation is the medical teaching profession. Many who hold leading positions in the medical schools foresee in health insurance a distinct threat to the future of medical education. This fear is based upon the assumption that under the Plan medical indigency, as we now know it, would disappear and all patients would receive medical and hospital care as insured persons. Moreover the privilege of choosing private or semi-private accommodation by paying the difference in charges would permit patients to vacate the teaching wards.

There is a fear, too, that should funeral benefits be provided under any comprehensive plan, anatomical material might become scarce, for it has been observed elsewhere that the provision of cash funeral benefits, even though very meagre, works wonders in bringing to light "relatives" never suspected. A few weeks ago representatives of the medical schools met in Ottawa to give serious consideration to these possibilities.

There is much ground for this apprehension and it will be necessary that provision be made in the enactment for the continuance of clinical medical education. To permit curtailment of clinical observation by medical students would so decrease the efficiency of medical training that irreparable harm would be done to the health of succeeding generations. Not only must present clinical teaching be maintained, but it was agreed at this meeting that there will probably be such an increased demand for medical care that possibly two or even three more medical schools may be required.

Both the Canadian Medical Association and the Canadian Hospital Council have urged upon the Drafting Committee and the Special Committee that every effort be maintained to preserve clinical teaching. The Draft Measure now provides that any insured person treated in the general wards "shall be available for clinical observation by the teaching staff of the medical schools and hospitals for the better instruction of students in medicine and nursing". Moreover, it is arranged that a teaching hospital may receive special compensation to meet certain expenses associated with teaching. This is not only to meet the cost of additional space, equipment and nursing attendance, but there is the thought in the minds of those who made this suggestion that certain added benefits or inducements might be developed to encourage patients to select teaching hospitals. Various proposals, some of them rather drastic, have been suggested to meet this situation. It is hoped that the enactment can be so worded that provincial regulations may be developed to meet the varying situations in different centres.

When health insurance finally goes into operation it may be found that the situation may not be as serious as it would now appear. The public is well aware of the excellent quality of service given in teaching hospitals and experience elsewhere would indicate that patients will still find this a drawing card. An outstanding example of this is the University of Chicago Clinics, where practically every patient is a paying patient, where all patients can be utilized for teaching and where the accommodation cannot equal the demand for admission.

## *The Intern Situation*

THE intern situation is not improving. Many hospitals are now without an adequate quota of interns and are reporting little if any success in obtaining interns for the fall. Hospitals are writing in insisting that the available supply of interns be rationed out to the approved hospitals and not permitted to remain in large numbers in certain favoured hospitals. Other letters would indicate that the Canadian Intern Board has not been fair in its allocation of interns. Still other letters insist that the Canadian Intern Board or the Canadian Medical Association Department of Hospital Service "do something" about it.

Many of these letters or telegrams indicate that there is still much misunderstanding respecting the work of the C.I.B. and the general procedure in arranging internships. It has been stated in these columns time and again that the Canadian Intern Board has absolutely no power to direct any intern to any hospital. The senior students, except where internships are controlled by the university, are free to select any hospital(s) they see fit; a list of such hospitals in order of priority is sent to the C.I.B. Meanwhile the hospitals have furnished the C.I.B. with a list of the applicants whom they wish to accept, either as first choice or as alternates. The C.I.B. then merely interweaves these two lists, assigning to hospitals those interns whom they wish to have and assigning the intern to the hospital highest on his list of choice.

Naturally there will be disappointments on both sides, but this is inevitable and the disappointments are proving far less numerous and come at an earlier date than under the old chaotic arrangement. Complaints are made that students who make early arrangements (off the record) are assigned to other hospitals, but invariably this has been found to be due to the student putting some other hospital higher on his list and not to any favouritism shown by the C.I.B.

One practice of hospitals bids fair to wreck the plan. Some hospitals write to students that they will not consider the application unless that hospital is promised first choice. Such effort to "beat the gun" is unfair to other hospitals and only encourages the students to say "yes" on all applications.

It does seem true that a higher percentage of students are remaining in the teaching hospitals. This is entirely due to the decisions of the students themselves and not to any action of the Intern Board. Internship is not required by any licensing body in Canada and the taking of an internship and the selection of a hospital are the free choice of the young graduates, except in those cases where the internship is part of the medical course, in which case students must go to hospitals selected by the medical school.

Some hospitals are badly handicapped geographically, but the main factor in selection is the opinion held by the student body respecting the opportunities for furthering their education in the different hospitals. To ration interns, except on a voluntary basis, would introduce a new factor into the whole programme of graduate education which would completely alter its nature and could only be affected by government regulation.

What is the solution? Even if interns be rationed, the number would be far from sufficient to meet the needs of the hospitals, and they would probably be assigned to a limited number of hospitals anyway. Modern medical practice has become so complex and requires so many clinical procedures that it is very doubtful indeed if the suggestion that staff doctors should do all their own ward work is really practicable. At this time, when the doctors who are left in practice are worked to death, they can hardly be expected to take ward Wassermanns, give all intravenous saline or glucose at the time when it is needed and write all histories. For the great majority of hospitals, if modern scientific hospital service is to be maintained, many of these clinical procedures will have to be done by laboratory technicians, by selected graduate nurses trained in the conduct of certain clinical procedures and by trained medical record librarians. All of this may not be ideal but we must be practical in our efforts to find a solution.

## *State Aid for Indigents*

IT is of interest to note the reaction of hospitals in the United States to the federal proposal to provide hospital insurance on a compulsory payroll deduction basis. When first announced, strong opposition was expressed by many hospital leaders, notably the late Dr. Goldwater. This has continued, although Dr. B. C. Maclean and others differed. At the recent New England Hospital Assembly, I. S. Falk of the Social Security Board debated federal vs. voluntary hospitalization with Dr. R. H. Bishop of Cleveland, staunch advocate of the Blue Cross plans. Dr. Bishop was supported by A.H.A. President James A. Hamilton, who expressed strong fears of what any Federal plan would do to voluntary hospitals. Opposition to the proposal was urged lest it result in governmental control and lowered quality of service. In a widespread poll of hospital opinion, *Hospital Management* found that there was an overwhelming opposition to the plan (697 to 97), and a confidence that Blue Cross plans would meet the need (652 to 108). However, there was a distinct majority in favour of Federal aid for the care of the indigent sick *if provided through the state* (520 to 263). Comments would indicate that there is strong opposition to any direct Federal interference or control, even though aid be provided.

As in Canada there would seem to be a desire to retain state or provincial autonomy. Such has advantages, although one cannot but feel that the arguments in favour of national uniformity are sometimes not fully realized. However, one weakness in the Washington plan would seem to be the proposal to pay the benefit in cash to the patient—not to the hospital. The formidable opposition even to a federal subsidy administered through local channels reveals a fear of government control not existent here. Only a handful of states have grants comparable to our highly desirable provincial grants, although the depression years broke down much of the opposition to this type of assistance. There is a mortal fear of the politician across the border. When we mention in discussion our seventy years or so of experience with grants with practically no political interference, we are told, "But you have a different breed of politician!" We doubt that very much, but we are happy to have such pleasant government relationships. Our hospital leaders feel that a measure of government supervision and control has been of real value to all concerned and that unwarranted interference can be checked by properly educated public opinion.

A real challenge has been laid down to the Blue Cross plans. They now provide for some 11,000,000 people, mostly in the middle income urban group. Rural people and those of intermittent or no income are not covered. According to Mr. Falk, the Social Security proposal would cover 80,000,000 to 100,000,000 people, including the indigent. The possible total amount available for hospitalization would be over eight hundred million dollars, much greater than the total annual hospital income now (1935 survey) of under five hundred millions of dollars. This is the challenge and it is a real one. To quote Mr. Hamilton: "We have got to move fast". Blue Cross leaders are fully alive to this situation and are making strong efforts to cover rural areas and to include low income groups. Appeals have been made to the hospitals to give more support by educational work and by providing more accommodation of the type needed. The next few years will show whether the hospital system in the United States can continue on an almost entirely voluntary basis, or will find it desirable to seek, or perhaps be obliged to accept, a partnership with the state.

# With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

## Survey of Nursing Conditions Made by British Doctor

*Dear Mr. Editor:*

Nurses are very much before the public at the present time. One is a detective in a thriller, another is the heroine of a "straight" love story, a third gives a plain narrative of her experiences and we are even promised a film in which a nurse takes a leading part. At the same time there is much concern in official quarters about the lack of young women coming forward to fill the ranks and an official committee under the chairmanship of Lord Rushcliffe has just recommended a substantial increase in their rate of pay. Of that I may have more to say on another occasion. Like a good many other people I do not believe that the amount of pay is the primary difficulty, but rather it is the conditions of the life or the popular conception of them which prevents girls from taking up this occupation. So I feel justified in singling out for notice a book just published on the subject.

### Nurses' Conditions

So far as I am aware no one has previously undertaken a study such as that incorporated by Dr. Sheila Bevington in a book dealing with "Nursing Life and Discipline" (London: H. K. Lewis & Co., Ltd., 7/6d). There have been two enquiries, initiated by *The Lancet* and the Inter-Departmental Committee, of which Lord Athlone was chairman, which have incidentally dealt with the subject as well as two books, one by a doctor and the other by a nurse, but Dr. Bevington has adopted the method of scientific enquiry by means of five hundred confidential interviews with nurses of different grades in five different hospitals and covering sixty per cent. each of probationers, staff nurses and ward sisters. Dr. Bevington has had considerable experience of this type of work under the auspices of the National Institute of Industrial Psychology and at the present time holds the post of Welfare Adviser in the great munitions firm of Vickers-Armstrong in Newcastle-on-Tyne. Dr. Bevington has also had some knowledge of hospital work as she took part in an interesting enquiry into the conditions of waiting in out-patient departments involving an examination of the psychological factors as regards the staff as well as the patients. Admittedly, closer familiarity with hospital life might have added to the value of her study, though it would hardly have substantially affected her findings.

### Hospital Discipline

Dr. Bevington's main conclusion is that the recruiting problem is not likely to be solved when peace returns unless hospital discipline is modernized. "The modern conception of discipline," she writes, "insists that, when a mistake is made, the authority in charge *investigates the cause,* instead of simply *observing the system* and *rebuking the offender.* And to do this takes more time and demands more patience and sympathy than an overworked Ward Sister usually has at her disposal."

### Suggested Reforms

Tabulating her proposals, Dr. Bevington plans first "widening the previous experience demanded of Sister Housekeepers". She would have specific teaching for the nurses on keeping physically fit. One thing to which Dr. Bevington gives the weight of her authority is the scientific investigatoin of the incidence, causes and prevention of sickness among nurses. It is a serious reproach upon the conduct of hospital managements that this has not been tackled thoroughly long since. The problem of the 96-hour fortnight is recommended for scientific research so that duty may be distributed to the best effect upon patients as well as the welfare of the staff. In some hospitals the Assistant Matron deals with staff problems such as the allocation of nurses to wards, and Dr. Bevington recommends the extension of this arrangement.

Personally I would have given higher place in her list of recommendations to the modernization of recruitment methods and interviewing techniques. The girl who has passed through a High School which provided an attractive prospectus setting forth the educational advantages from which she might hope to benefit and in which she and her parents were received with courtesy and cordiality, cannot fail to be impressed unfavourably by an atmosphere in which everyone concerned seems to be conferring a favour.

Dr. Bevington's proposals for giving instructions to senior probationers and Staff Nurses in the methods of training and handling subordinates opens up a wide range of discussion. So also do those which concern discipline, such as representative councils and the rights of appeal to the managing committee, which are being brought into operation in an increasing number of hospitals.

### Analogies with Industry

One proposal deserves separate

*(Concluded on page 56)*

# CURITY LAYETTECLOTH* DIAPERS...

## for modern technic and wartime economy

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REG. IN CANADA

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*Reg. in Canada

**DRESSINGS • SURGICAL SUPPORTS • SUTURES**

# Much Progress Made at Meeting of Maritime Conference, C.H.A.

The Annual Meeting of the Maritime Conference of the Catholic Hospital Association was held in Antigonish, N.S., on April 29-30, under the presidency of Sister St. Stanislaus of Chatham, N.B.

At this meeting lively discussions took place, largely centred about the proposal for National Health Insurance and the Group Hospitalization Plan being developed in the Martime Provinces. The work of the Canadian Advisory Board of the C.H.A. in connection with the health insurance measure was reviewed.

A committee for the study of health insurance had been formed following the 1942 convention in Montreal. This Committee, formed with the assistance of Rev. Father Schwitalla, was made up of three advisers, Rev. Father Bouvier of Montreal (Chairman), Rev. John R. McDonald of Antigonish and Rev. Father Brennan, of London; three administrators, Mother Ignatius of Glace Bay, Mother Allard of Montreal and Sister Dorais of St. Boniface; and representatives of three nursing schools, Mother Allaire of Montreal, Sister Beatrice of Lethbridge and Sister St. Stanislaus of Chatham, N.B.

The report of this Committee was later presented to the Committee of Bishops—Archbishop Vachon of Ottawa, Archbishop McNally of Halifax and Bishop Carroll of Calgary. This Committee has done good work in protecting those principles which would be considered essential to Roman Catholic hospitals and schools of nursing.

It was reported that Nova Scotia is now prepared to launch a provincial Group Hospitalization scheme, a charter having been approved by the legislature. It is hoped that Prince Edward Island and New Brunswick will follow shortly. Further discussion will take place at the Maritime Hospital Association meeting in Kentville at the end of June.

Progress was reported in effecting the federation of Catholic graduate nurses right across Canada. The plan of grouping nurses in each province into separate units has been considered to be the first step towards this federation. Now the scheme has reached the stage of ecclesiastical interest "and we see our eager hopes of the past about to flower into buds of promise". Rev. Father Daly, S.J., of Montreal, National Chaplain of the C.Y.U., has agreed to include graduate nurses as part of the youth organization.

The formation of the Catholic Hospital Council of Canada was noted. This replaces the former Canadian Advisory Board of the Catholic Hospital Association. Whether or not the Conference will change their names to co-ordinate with the Catholic Hospital Council of Canada is now under advisement.

Instructive addresses were heard from Rev. Father John R. McDonald of Antigonish, Rev. Doctor M. C. Coady and Rev. Father Chisholm of St. Francis Xavier University, Rev. Father McIsaac of Glace Bay, Rev. Father McAdam, spiritual director of the M.C.C.N., and Dr. J. A. MacMillan of Charlottetown, President of the Maritime Hospital Association.

The invitation of Rev. Mother St. Teresa of the Hotel Dieu Hospital at Campbellton, N.B., to meet there next year was accepted.

# Government Declines to Approve Badges for Hospital Workers

The request of the Canadian Hospital Council for government recognition of a button or badge to be worn by hospital workers has been turned down by the Department of Labour. This matter was taken up with National Selective Service last year, but a decision was not made until last month. With all women and most male employees of hospitals in a high essential category, it has been the opinion of hospital people that the recognition of a button for hospital workers, such as has long since been approved by the government in Great Britain, would do much to make hospital employees (and their acquaintances!) realize the wartime value of their work.

Mr. MacNamara replies:

"You will realize that if we were to issue badges such as you have in mind, these could not be confined to hospital workers. The same privileges would have to be extended to persons engaged in all the other essential occupations.

"This whole matter has been given very careful consideration by officials of National Selective Service, and it has been decided that it would not be advisable to issue any badges of this nature at the present time."

If hospital workers desire a badge, it will be necessary to adopt one without government recognition. This can be done without further ado, as has been done in the U.S.A., where the American Hospital Association has made available at low cost tens of thousands of neat little buttons for the use of hospital workers. A number of Canadian hospitals, we understand, have ordered these buttons. While not as effective as though official approval had been given, they can nevertheless serve a useful purpose, provided care be taken that they be worn only by those hospital workers in essential categories.

### National Hospital Day Celebrated in Saint John

On National Hospital Day (May 12), the graduating class of St. Vincent's Girls' High School was invited to visit St. Joseph's Hospital in Saint John, N.B.

They were shown the hospital's blood bank, an operating room set up in readiness for an operation and the dietary department, where special diet trays had been prepared, including a diabetic. Following their tour of the hospital, luncheon was served in the nurses' dining room.

New Brunswick, in 1917, was the first province in Canada to have a Minister of Health.—C.P.H.A.

# Tougher than a drill sergeant

. . . are the technicians who inspect Abbott's intravenous solutions. For them it is not enough that the solution *look* right. Every manufactured lot of Abbott liter solution must also pass exacting scientific tests for sterility and absence of pyrogenic effect. And if at any point, the solution fails to pass an examination with a perfect mark, the entire lot is destroyed. No liter solution ever bears the Abbott label unless it has passed tests as rigid as those used in the manufacture of ampoules. Even the container is specially designed with tamper-proof seal, inner cap which may easily be removed without touching the lip of the bottle, and capliner impervious to attack by the chemicals in the solution. For illustrated literature on Abbott intravenous solutions in bulk containers and dispensing equipment, write to ABBOTT LABORATORIES LIMITED, Montreal.

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**IN BULK CONTAINERS**

# Is the Proposed Health Insurance Measure Entirely Satisfactory?

By G. H. A.

IN previous issues we have referred to the obvious need for correcting some of the weaknesses in our health system and have indicated our confidence that the proposed health insurance measure would go a long way to overcome some of these weaknesses.

However it is only fair to state that there are some details of the draft which are either not clear or are of concern to those studying the measure. A few sections are ambiguous, others do not seem to have the best wording and some points are not adequately covered.

To a certain degree this can but be expected, for it has been the intention of the Committee that the model provincial Act should be one of general guidance only, leaving many of the details to be worked out as would best seem to meet the needs of each province. This phrasing has virtues over a hard and fast, fully-detailed measure which might not suit all provinces equally well, although certain fundamental points should be clearly stated in the enabling act as being mandatory upon the provinces.

**Indigency.** For example the inclusion of the indigent is a feature of major importance, yet its obligatory inclusion is nowhere clearly required. Its inclusion can be interpreted from certain clauses, and the Honourable the Minister has so stated, but we would be happier to see it clearly set forth in black and white. Unless indigents be covered, the support of the measure by those providing the services would probably be reduced to the vanishing point. This inclusion is a "must".

**Reserves.** It does not seem clear, either, as to whether the hospitals and the professions supplying the services will go short in case of epidemic or unusual demand upon the services, or whether there will be any reserve built up for periods of strain as in the case of unemployment insurance. Hospitals and the professions must be assured of remuneration for services rendered.

**National Council of Health Insurance.** Section 16(4) assigns to this body "such duties and powers as the Governor-in-Council may prescribe". As it is understood that this body is to be purely advisory, a re-wording of this clause would seem indicated.

This National Council would seem heavily loaded with public health officers. Although the medical profession, the hospitals, the nurses, the dentists, labour, agriculture, etc., are to have but one member each, the deputy minister of health of each province is to be a member irrespective of whether or not that province has a plan.

**Additional Committees.** Section 45 authorizes the provincial Commission to "recognize" committees representative of hospitals or the professions for purposes of consultation. However, section 46(1) states that "in addition . . . the Commission may . . . establish such committees, councils or other bodies . . . as may be deemed advisable for consultative, advisory, administrative or executive purposes or (the italics are ours) *for the purpose of securing effective co-operation* in the administration of this Act". This also may be necessary to get on with the job, but there is always the threat that if we find the Act an impossible one and refuse to co-operate, a committee will be named that will co-operate.

**Medical Education.** The Importance of safeguarding medical education is obvious. This must be clearly covered in the regulations (see editorial).

**Division of Jurisdiction.** It would seem necessary to define more clearly what comes under Public Health and what under the Health Insurance Commission. Both the First and the Third Schedules would seem to place more diagnostic and therapeutic work under public health than would be acceptable to many members of the healing professions. There is a strong feeling on the part of some that certain diagnostic and therapeutic activities for which grants would be given, such as cancer control, should be under the Commission rather than the Health Department.

**Payments.** In section 26(2) the Provincial Treasurer "may" pay out of the Fund any sums requisitioned by the Commission. Is this a sword over the Commission's head, or should the word be "shall"? We have been hoping for an independent non-political Commission.

**Drugs.** Doctors are not allowed to supply drugs, medicines or appliances except for immediate use, in emergencies or in remote areas [30(1)(a)]. Such can be supplied only by registered retail pharmacists. This will prevent all office dispensing (except as above) by doctors—a common practice in Ontario and the Maritimes. What effect will it have on hospitals? Will it prevent a doctor or intern making up a bottle for a departing patient in the absence of the pharmacist? Is a licensed doctor barred from supplying medicine?

**Partial Service.** In certain rural areas it may be possible to give but a partial service for some years to come. While this is considered [33(3)], it is not stated whether the people in those areas would be required to pay the regular contribution, or but a portion of it.

**Ambiguities.** There are a number of ambiguities, or apparent ambiguities, which will probably be ironed out before the measure becomes law.

Undoubtedly many of these points will be clarified before the draft leaves the hands of the Special Committee on Social Security. As it stands it is a real credit to the Drafting Committee, but further improvement should be made where possible. Present indications are that the Special Committee, which is now working on the measure, is making every effort to pass on to the House a practicable and sound measure. So much may happen, however, and so many good clauses may be mutilated or weakening ones inserted, either in the Committee or, more likely, in the House, that approval must always be subject to these revisions. Actually the nature of the subsequent regulations and by-laws will really determine the true value of the measure.

# Alberta Hospital Associations Make Recommendations Respecting Soldiers' Dependents

THE following memorandum respecting the hospitalization of soldiers' dependents has been prepared and submitted by the Alberta Hospital Association and the Alberta Municipal Hospitals Association. These comments and recommendations will be of interest to hospitals in other provinces.

MEMORANDUM
re Hospitalization of Dependents
of Members of
the Armed Services.

A recent survey by some of the hospitals in central and southern Alberta indicates that the hospitals in the province of Alberta are confronted with a very serious problem which, unless immediate remedial measures are undertaken, will become intensified and be an intolerable financial burden on our hospitals.

We wish to draw to the attention of your Board the fact that *a large number of accounts incurred for the hospitalization of dependents are outstanding and at present appear to be uncollectible unless paid through the medium of your Board.* Many of these accounts are owing by dependents who have been refused assistance by the local Dependents' Advisory Committee or in some few cases, your Board has apparently denied the recommendation of the Committee, despite the fact that the debtors claim inability to pay for such hospitalization from their assigned pay and dependents' allowances.

This situation creates dissatisfaction and resentment among dependents and members of the Forces, who on return to civil life, will find themselves confronted with collection efforts by hospitals endeavouring to liquidate accounts still unpaid but for the payment of which, when incurred, the government through appointed agents declined assistance and ruled that the dependents could pay. Such a policy is and will be contrary to the government-announced policy of rehabilitation for members of the armed services.

Arguments have been advanced that if the Dependents' Board of Trustees did not exist, the accounts paid by the Dominion Government on the recommendation of the Committees would never be collected by the hospitals. The hospitals of Alberta are not prepared to accept any such statement and in any event if such argument is justified, it merely proves the necessity for the fund which is administered by your Board; however, such an attitude is not a fair method of conducting national business with institutions which are providing a necessary public service.

#### Conflict of Opinion

There appears to be a tendency to interpret "special or urgent need" as a state of destitution with the result that a large number of applicants are refused assistance. The government of the Dominion of Canada is not likely to admit that the scale of assigned pay and dependents' allowances places any family in a state of destitution; therefore, it would appear that there exists a conflict of opinion between the Minister of National Defence and the Dependents' Board of Trustees or Regional Dependents' Advisory Committees as to the proper interpretation of "special or urgent need".

> Note: (The Hospitals Act of Alberta makes provision for the hospitalization of indigents but the local authorities — cities, towns, villages, and municipalities—do not consider the dependents of members of the armed forces to be indigents or destitute. Owing to the movements of such dependents, many of them are unable to qualify as a resident of any local authority, or even of this province.)

We are of the opinion that the problem of dealing with the accounts of these dependents has been aggravated by the circulation of a pamphlet sent to the recipients of dependents' allowances calling attention to the fact that the Department of National Defence has made arrangements for supplementary grants to provide assistance to meet the costs of hospitalization, etc. We have also been informed that this pamphlet is either read or referred to over the radio in connection with recruiting campaigns and to new recruits at or shortly after attestation.

#### Recommendations

We therefore suggest and recommend as follows:

1. (a) **That the Department of National Defence take immediate steps to dispel the general impression created by the circulation of a pamphlet headed "Department of National Defence — The Dependents' Board of Trustees, Records Building, Ottawa, Ont., August, 1942", that all dependents' hospital, etc., acounts may be paid by grants provided by the Dominion government** and (b) **that the circulation of what appears to be a misleading pamphlet** (the contents of which do not appear to be properly understood by those to whom it is directed) **be immediately discontinued,** or alternatively, (c) **that the pamphlet be redrafted** so that there may be no misunderstanding as to whom assistance may be granted and **that paragraph 6 be changed to paragraph 1.** While it may not have been the intent, the pamphlet has created among dependents and members of the forces the idea that hospital accounts would be so paid.

2. (a) **That a definite national policy be determined for the guidance of Advisory Committees;** (b) **that any contracts entered into between any body or group such as hospitals, doctors or dentists be subject to approval of the proper government department** and (c) **that the fact that such contracts may be or may have been made be established** and (d) **the terms of such contract or contracts now in existence be made available** on written request to the president or secretary of a provincial hospital association for the information of member hospitals.

3. (a) **That if payment of the full amount of the acount is not recommended by the Committee, the present policy of some Com-**

**mittees of demanding a discount as a condition of a recommendation for payment be discontinued**; (b) **that any payment made through the Advisory Committee be considered as partial assistance and hospitals retain the right to collect, if possible, the difference between the amount paid by the government and the original amount of the acount**; collection of this balance to be made during the War or after discharge from the armed forces as any hospital may decide.

4. **That the Dominion government set a definite rate which will be paid for the hospitalization of dependents.** (This is necessary to avoid discrimination against municipally-owned hospitals which grant a low rate to ratepayers, or against those which operate hospital insurance schemes or contracts and whose charges are not basic rates.)

5. **That the rate for general ward beds be $2.50 per day*** plus **fees for necessary services** such as laboratory tests, x-rays, case room, operating room, etc., and that such charges be not subject to discount. This rate is much below the cost per hospital patient day for the average hospital in Canada.

Under present conditions much trouble and ill-feeling could be avoided **if Advisory Committees would investigate applications for assistance from dependents anticipating hospitalization,** such as expectant mothers, elective but necessary surgery, etc., and decide as to whether or not the Committee would recommend assistance. All such investigations and decisions should be completed as early as possible, and the decisions conveyed in writing to the applicant for presentation to a hospital at the time of admission.

The hospitals of the province of Alberta duly appreciate the voluntary work of the members of the Dependents' Advisory Committees, many of whom doubtless sacrifice a great deal of time in connection with this task; however, we are of the opinion that a more sympathetic approach would be justified when consideration is given to application for assistance to meet necessary hospital acounts.

We believe it would be in the best interests of all concerned **if the Dependents' Board of Trustees entered into approved standard contracts with hospitals, such contracts to be negotiated by the Board with provincial hospital associations.**

We respectfully submit the above suggestions and recommendations for your favourable consideration and early action.

The Alberta Municipal Hospitals Association,
"J. McD. Taylor",
President.

The Alberta Hospital Association,
"J. M. Findlay",
President.

*This amount would not necessarily be satisfactory in other provinces.—Ed.

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# Voluntary Hospitals Urged to Co-operate in Planning Health Insurance

"There is a growing belief, amounting to a conviction, in government circles and in the public mind that, if we are to deal adequately with the problems of post-war re-adjustment, and to prevent a recurrence of the crisis in economic and social life which characterized the pre-war decade, it will be necessary that the government take positive action to provide increased security for the people in the lower income groups . . .

"Two methods of dealing with the problem of sickness in the community are currently mooted—state medicine and compulsory contributory health insurance.

"State medicine, including hospitalization, contemplates the provision of all health services by employees of the state at public expense. It would provide hospital care in state-owned and operated institutions. Such a system, quite clearly, would have no place for the voluntary hospital which would pass out of existence either through expropriation or through lack of patronage by its present clientele.

"Fortunately, this conception has little, if any support save from a minority of those professing the more radical political philosophies. The majority opinion among progressive thinkers, both within and without the government, leans strongly towards the principle of *compulsory contributory health insurance.* Under this system the individual is required to make small regular contributions to an insurance fund and the cost of illness is defrayed by payment from the fund to those individuals or agencies providing medical, nursing or hospital care. It is clear that this system is essentially a means of assisting the individual to assume the responsibility, within his means, of financing the cost of his own and his dependent's illnesses. There is no interference with the right of the individual to freedom of choice in the selection of his hospital or medical attendant, other than a probable regulation that such choice be limited to legally recognized practitioners and hospitals.

"Bearing in mind the almost exclusive use of the voluntary hospital by governments in the past, it is evident that these institutions are slated to provide hospitalization for the contributors of the insurance plan. This being so, it is unquestionably in the best interest of these hospitals to co-operate fully with the government by placing their accumulated experience freely at the disposal of the departments engaged in the drafting of this legislation . . . Should there develop any attitude of obstruction or lack of co-operation by the voluntary hospitals, they would not only find themselves powerless to affect the issue, but would sacrifice this preferred position as adviser in the preparation of the legislation, and probably in subsequent administrative control as well. There is no virtue in a policy of intransigeance in this matter, at this time. I believe that a policy of helpful co-operation together with an insistence on our right to be heard and heeded in the capacity of expert advisers, will be productive of a type of legislation best suited to our hospitals and to the public."

*O. C. Trainor, M.D., Winnipeg,*
*Excerpt from "Hospital Progress."*

# Hospitals Can Learn Much from the St. John's Conflagration

## A Warning Given to Civilian Hospitals

OBSERVATIONS by competent medical authorities following the catastrophic fire in a Knights of Columbus Leave Centre in Newfoundland have considerable significance for the staffs and administration of our civilian hospitals. Equally valuable comments were issued following the Boston night club fire.

Squadron Leader A. W. Farmer, R.C.A.F.; Surgeon-Commander D. R. Webster, R.C.N.V.R. and Surgeon-Lieutenant F. M. Woolhouse, R.C.N.V.R., have made several serious observations, which might as readily have been applicable to other centres.*

No one had learned to wrap burns up and leave them alone.

There was in no case preparation for such a disaster, in the manner of the formation of a trained "burn team" in the different hospitals—service or civilian.

Measured fluid outputs and fluid intakes, vomiting, temperature reactions, etc., were much neglected in noting patient reactions.

Civilian doctors did not know where to obtain serum and thus used practically none.

Materials for local application were inadequate and the correct materials were not abundant and handy.

Laboratory facilities were inadequate.

### Dr. R. I. Harris Comments

Comment was made upon this report by Dr. R. I. Harris, of Toronto. He wrote on behalf of the Sub-committee on Surgery of the Associate Committee on Medical Research of the National Research Council.†

The actual treatment of the burns may be but a small part of the problem of medical management. Carbon monoxide poisoning, asphyxiation and noxious fumes from the incomplete combustion of cellophane decorations or fabrikoid upholstery must be considered. The latter cause pulmonary lesions similar to those caused by phosgene or nitric oxide. Obstructed exits may result in crushing injuries or mechanical suffocation. Pulmonary oedema is usually the most important complication.

The sudden necessity of handling a large number of casualties could easily swamp the facilities of the best organized civilian hospital. The situation in the Massachusetts General Hospital was saved by the well-organized casualty squads of the Civilian Defence Corps, who relieved the overburdened staff of all responsibility except the actual treatment of the injuries.

**"The most important service which can be rendered by the present report will be the warning to civilian hospital organizations across Canada that such disasters can occur and that preparations for them should be made."**

It is important that every community should foster its C.D.C. and be prepared to use it should tragedy overwhelm them.

*For hospitals the lesson is to plan some form of organization which can be quickly called into action in the event of a catastrophe.*

The whole hospital staff should be organized into teams, planning and practising until reasonable efficiency be attained.

There should be a reserve of dressings, bandages, sulfonamides, intravenous solutions, tubing and needles, plasma and splints. Every large hospital should have a blood and plasma bank or a stock of commercial dried plasma. Hospitals should be familiar with the facilities which will shortly be available for the supply of dried serum from the Army (Central Medical Stores) in the event of a great calamity.

An excellent article on "The Early Recognition and Treatment of Shock" appears in the same issue.

Writing in *Hospitals* on the Cocoanut Grove disaster, Dr. N. W. Faxon and Dr. E. D. Churchill referred to the importance of a well-planned and organized telephone service. They also referred to the necessity of the immediate examination and separation of the living and the dead at the entrance to the hospital, not in the Emergency Ward. It is important, too, to have the staff and nurses divided into teams and to concentrate casualties in one group where they can be under concentrated medical treatment. Anxious families and friends must be recokned with, and arrangements made for their reception and control.

One important defect in the casualty organization was the impossibility for those responsible for the care of the survivors to secure adequate information regarding the character of the trauma. No information regarding the disaster or the possibility of poisonous fumes could be obtained.

The Emergency Ward should be selected in advance. Guards should be obtained and only persons bearing passes and acceptable to those in charge should be admitted. Lists of the living as well as of the identified dead should be made as quickly as possible. Police assistance should be obtained as soon as possible to control yard traffic and to guard corridors and morgue.

In an article in *The Modern Hospital* on the same subject, Dr. John Gorrell emphasized the importance of providing for the custody of valuables found on the victims.

*Can. Medical Association Journal 48:3, 1943, pp. 191-195.
†Ibid.

### Shortage of Help Closes Hospital Wings

One 16-bed section of the infectious diseases hospital in Halifax has already been closed down on account of the shortage of general help, particularly maids and cooks. It is feared that several wards of the Victoria General Hospital in the same city may also have to be closed.

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## Squadron Leader Sellers Receives Award For Compilation of Hospital Statistics

Squadron Leader A. Hardisty Sellers has been awarded one of the medals presented annually by the Professional Institute of Civil Service of Canada for outstanding contribution to Canada's war effort and to "national and world well-being".

The medal was awarded Dr. Sellers in recognition of his studies of public hospital statistics in Ontario between 1900-1938. This was undertaken while he was director of the Division of Medical Statistics of the Ontario Department of Public Health. It is stated: "While the

survey undertaken by Dr. Sellers is of particular value to the Province of Ontario, the judges took the view that his study was both useful and timely and would unquestionably be of great assistance to any government in ascertaining basic costs and all other pertinent material in setting up any scheme of health insurance."

The survey involved the investigation of more than 60,000 hospital admissions. Dr. Sellers' analysis showed that between 1900 and 1938 the number of patients treated in hospitals had increased from 14 to 75 per thousand inhabitants, hospital facilities from 2 to 4 beds per thousand, and the average number of days' hospital care given to each inhabitant from one-third of a day to almost a full day. Operating costs per patient per day have increased from less than $1.00 to $3.75. Approximately 43% of all patients in Ontario hospitals in 1938 were indigent and this group necessitated 56% of all days of care during the year.

Since joining the Royal Canadian Air Force, Squadron Leader Sellers has organized a most complete system of medical records and statistics. He has been appointed Chairman of the Committee of Registration and Certification of the Canadian Public Health Association, and Medical Statistician to the Canadian Medical Procurement and Assignment Board.

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### Printing Error at Ottawa Substitutes Wrong Memorandum

Members of the Health Insurance Committee of the Canadian Hospital Council are "burning up" these days. A few weeks ago the Government issued a very elaborately compiled Report of the Advisory Committee on Health Insurance which includes not only the draft measure but a very comprehensive section on vital statistics with charts and maps, and the recommendations and submissions of the various national bodies consulted by the Advisory Committee.

When the Health Insurance Committee of the Canadian Hospital Council made its presentation in May of last year it was congratulated on being the first organization to submit its recommendations to the Advisory Committee. These recommendations and principles were later published in *The Canadian Hospital* for October. Imagine the surprise and annoyance of the Committee to note that this Memorandum of the Canadian Hospital Council was not printed in the large report but in its stead under the heading of the Canadian Hospital Council was included, with no explanatory note, some rough draft comments sent in at a later date to the drafting committee as suggested items for inclusion in the regulations to be drawn up to supplement the Act!

Obviously this was a mistake and the regrets of the Advisory Committee have since been received. Nevertheless, the use of these disjointed paragraphs complete with marginal working notes for the use of the Advisory Committee do make the hospital "presentation" look ridiculous and absurd when compared with the carefully worded memoranda of the various associations here grouped together. Unfortunately this volume has been sent far and wide to key organizations and individuals both here and abroad. The printing has been exhausted, we are informed, and efforts are now being made to have this error corrected should a subsequent printing be made.

## *With The Auxiliaries*

**From New Brunswick**

The last meeting of the season for the Women's Hospital Aid of the Saint John General Hospital was marked by an address on the work of the A.R.P. by Mr. A. Dodge Rankine, municipal A.R.P. officer. Mr. Rankine reminded his audience that the danger of an attack on this side was by no means over, and urged more volunteers for clerical work with the A.R.P. and to staff concentration points for evacuation.

Mrs. Percy N. Woodley, president of the aid, was appointed delegate to the Maritime Hospital Association convention in Kentville.

* * * *

**From Ontario**

Mount Sinai Hospital in Toronto is fortunate in having seven energetic and well-organized auxiliaries, working for the hospital under the guidance of a directing Council. The combined active membership of these aids is 400, and an average of $10,000 to $12,000 is donated to the hospital each year.

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**Hospitals Benefit in Will**

The three Windsor, Ontario, hospitals—Metropolitan General, Grace and Hotel Dieu, have each received $10,487.38 from the estate of Mary Wintemute.

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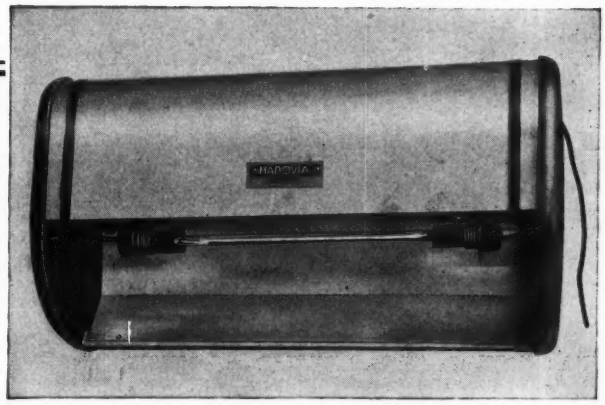


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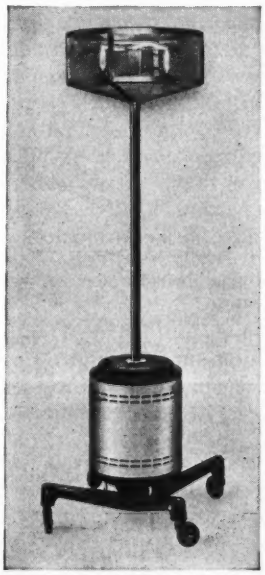

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*(Suite de page 22)*

certains patients, étrangers ou autres, les hôpitaux ne reçoivent aucune compensation municipale, de même qu'elles sont plutôt très rares les municipalités qui paient pour les malades de dispensaires.

Les administrateurs des hôpitaux, qui sacrifient à la cause des malades leur temps et leur pensée, comprennent très mal ces controverses et accueilleraient volontiers un arrangement qui les éliminerait.

## ASSURANCE-MALADIE

Le Conseil des Hôpitaux du Canada *approuve, en général, le principe de l'assurance-maladie.* Cette opinion n'est pas nécessairement celle des conseils d'administration des hôpitaux particuliers, des conseils des hôpitaux dirigés par des religieuses hospitalières, ni celle des services gouvernementaux qui assistent dans son travail le Conseil des Hôpitaux du Canada. En outre, cette opinion ne comporte aucune approbation d'un plan particulier.

Il est admis que les frais de maladie sont tels, pour la moyenne des patients, qu'on devrait adopter une mesure propre à les en délivrer. Les frais d'hospitalisation s'abattent sur le patient au moment où ses revenus lui manquent; il faudrait en répartir le coût sur les gens en santé, qui sont plus aptes à les défrayer.

### Principes Essentiels

Il est cependant à souhaiter vivement que toute mesure d'assurance-maladie sauvegarde ce que notre système actuel d'hospitalisation a de meilleur. Il serait possible d'en retenir les bons éléments, d'en éliminer les autres et d'en combler les lacunes sans le changer du tout au tout.

**1. Les hôpitaux à charte indépendante devraient être maintenus.**

Il est particulièrement souhaitable que soit préservé le principe de liberté en ce qui regarde l'hospitalisation. Près de deux cent millions de dollars ont été dépensés pour la construction des hôpitaux indépendants, laïques ou religieux, et il est impossible d'apprécier à sa juste valeur la somme des efforts et des sacrifices de ces innombrables volontaires qui ont réussi à les maintenir en opération. On devrait tendre, non pas à détruire l'effort volontaire et à le remplacer par des services étatisés, mais à établir une forme de coopération qui assurerait à l'effort personnel et volontaire, l'aide et l'appui de la société, en général.

*C'est pour cela qu'il est désirable que l'on continue d'utiliser les hôpitaux actuels pourvu qu'ils se conforment aux standards de services établis par la Commission ou par un autre corps dirigeant.*

Cela implique, pour les patients, *le droit de choisir l'hôpital qui leur convient,* pouvu que cet hôpital se conforme aux standards requis et que le patient tombe dans l'une des catégories de malades reçus dans l'hôpital qu'il a choisi.

**2. L'hospitalisation devrait être exclusivement réservée aux hôpitaux publics.**

A moins d'un arrangement spécial, les hôpitaux qui pourraient recevoir le paiement des services rendus aux assurés devraient être ceux que les gouvernements provinciaux reconnaissent comme hôpitaux publics, i.e., les hôpitaux à charte indépendante, sans but lucratif (laïques ou religieux) et les hôpitaux dits municipaux.

On pourrait cependant faire exception en faveur de certains hôpitaux privés qui sont seuls à desservir les populations de vastes étendues rurales.

**3. Les versements aux hôpitaux devraient être adéquats.**

Ils devraient couvrir:

(a) les soins généraux;
(b) les remèdes, le matériel à pansements et les appareils;
(c) les charges pour usage des salles d'opération et des salles d'accouchement;
(d) les recherches de routine de laboratoire ou autres;
(e) la physiothérapie et les traitements d'orientation professionnelle, quand la chose est nécessaire;
(f) au besoin, les services de garde-malade privée;
(g) d'autres charges jugées indispensables et approuvées par le bureau de contrôle.

**4. Les hôpitaux devraient être en mesure de traiter toutes les catégories de patients.**

Actuellement, il y a insuffisance sous ce rapport. Dans la plupart des provinces, on manque de disponibilités pour le traitement des maladies chroniques ou incurables. Il en est de même aussi pour les convalescents. Le traitement des convalescents permettrait aux hôpitaux bien équipés de libérer davantage leurs lits, et aux malades de reprendre plus tôt leur travail. La plupart des provinces manquent aussi de facilités pour le traitement de la tuberculose et des maladies mentales. Sauf dans quelques centres, on y manque également de salles d'observation pour certaines formes frustes de maladie mentale dont la cause est à rechercher. On pourrait en dire autant des malades qu'il faut isoler, des alcooliques et des narcomanes. Bien que les refuges pour vieillards et infirmes puissent difficilement être considérés comme des hôpitaux, leur nombre insuffisant devient un problème social très sérieux qui obère le fardeau des hôpitaux généraux.

Pour satisfaire tous ces besoins, l'assistance de l'Etat devrait suppléer l'insuffisance de l'effort volontaire.

**5. Le projet d'assurance-maladie devrait pourvoir à l'hospitalisation des indigents.**

Il est fort désirable que tout plan d'assurance-maladie étende sa protection sur ceux qui ne peuvent rien payer, aussi bien que sur ceux qui versent des contributions. Les patients pauvres devraient recevoir, dans les hôpitaux, les mêmes traitements que ceux qui sont assurés. Si le plan prévoit une rémunération adéquate au coût d'hospitalisation, comme cela devrait être, le système actuel des paiements municipaux et des gratifications provinciales n'aura plus sa raison d'être.

**6. Le plan devrait inclure les dépendants des personnes assurées.**

Un plan d'assurance-maladie devrait inclure non seulement le soutien d'une famille, mais aussi tous ses dépendants. Il assurerait le bien-être de la nation, en

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# WHEREIN WE SERVE . . .

*"The quality of mercy is not strain'd,*
*It droppeth as the gentle rain from heaven*
*Upon the place beneath. It is twice blest:*
*It blesseth him that gives and him that takes . . ."*

*Shakespeare, ("The Merchant of Venice")*

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incluant tous les enfants, quel qu'en soit le nombre, sans exiger une surprime de la part des parents.

**7. La rémunération des hôpitaux devrait être adéquate.**

Comme nos hôpitaux, à peu d'exceptions près, n'ont pas de dotation et qu'ils défraient leurs dépenses à même les revenus de leurs divers services, il est essentiel qu'ils reçoivent une rémunération adéquate du Fonds d'Assurance:

(a) afin de permettre le traitement efficace des patients, conformément aux standards actuels;
(b) afin de couvrir le coût d'hospitalisation;
(c) afin de pourvoir à un fonds raisonnable de dépréciation et d'extension des services essentiels;
(d) afin de permettre l'enseignement et le travail d'éducation sociale.

**8. La base de rémunération devrait être équitable pour toutes les parties en cause.**

On devrait trouver une base équitable pour l'hôpital, d'une part, et pour le Fonds, d'autre part. Il faudrait reconnaître le fait que le coût d'opération peut varier et devenir grandement affecté par un outillage de grand prix, par des services spécialisés, par l'emploi d'un personnel compétent et, dans le cas de petits hôpitaux, par l'intermittence du patronage et le coût d'approvisionnement.

Comme il se peut que l'on envisage diverses méthodes de paiements alternatifs, il est à recommander que, dans chaque province, on étudie une base de paiements avec la collaboration des représentants des hôpitaux.

**9. Les hôpitaux devraient conserver le droit de déterminer les privilèges concédés à leur personnel.**

La législation actuelle exige des hôpitaux qu'ils fassent preuve de rigueur et de jugement dans le choix de leur personnel médical. Cette exigence se base sur le droit de l'Etat d'assurer des soins convenables aux malades dont il supporte les frais d'hospitalisation. Ce choix est ordinairement fait par les gouverneurs ou les administrateurs, sur la recommandation écrite d'un comité ou conseil médical. Les privilèges des hôpitaux sont très utiles aux médecins; et la plupart d'entre eux, s'en prévalent dans l'exercice de leur profession. Certains médecins ont le privilège de traiter des cas privés seulement; d'autres s'occupent de plus des patients d'assistance publique. L'assurance-maladie peut modifier ces privilèges. Cependant, comme les hôpitaux ont la responsabilité de leurs patients et qu'ils se font juste gloire de la réputation acquise, ils sont opposés à ce que des intérêts étrangers viennent les contraindre à diviser leurs privilèges, de nature purement technique, à des médecins que les administrateurs, sur l'avis du corps médical, jugeraient inaptes à les exercer convenablement. Si cette sauvegarde de leurs privilèges disparaissait, il serait bien difficile de maintenir l'intérêt et l'enthousaiasme qu'apportent à la cause des hôpitaux une foule d'hommes et de femmes animés du meilleur altruisme.

**10. Les assurés devraient avoir le privilège de se procurer des commodités exclusives, s'ils veulent en acquitter les frais.**

On présume que la Plan établira un standard de commodités pour les patients; quelque chose comme ce que l'on donne actuellement aux patients d'assistance publique. Si les patients désirent une chambre privée ou semi-privée et des services spéciaux, non prévus par le Plan, on devrait accéder à leur désir, à condition qu'ils paient la différence du coût.

**11. L'assurance-maladie devrait être établie sur une base provinciale avec un lien fédéral de coordination.**

Il semble pratique que l'assurance-maladie soit introduite sur une base provinciale, mais avec une certaine entente avec le gouvernement fédéral qui l'aiderait pécuniairement et qui, seul, pourrait fondre les divers plans provinciaux en un vaste plan national.

On base cette prétention sur les raisons suivantes:

(a) Les conditions varient tellement d'une province à l'autre qu'il serait beaucoup plus difficile de les adapter à un plan national qu'à un plan provincial;
(b) Comme il est difficile d'établir des données précises sur la mortalité, le coût, etc., dans l'ensemble du Canada, il faudrait anticiper des révisions subséquentes du coût, d'hospitalisation et, survenant un déficit par suite de prévisions budgétaires inadéquates, il serait plus facile de réajuster un plan basé sur une échelle provinciale que sur une échelle fédérale.
(c) Un plan national ayant une administration fédérale entraînerait probablement des amendements à l'acte de l'Amérique Britannique du Nord.

**12. La direction du plan devrait être indépendante de toute politique.**

Parce que la santé de notre peuple importe éminemment au bonheur de la nation, toute ingérence politique devrait être bannie de la direction du Plan. Nous opinons que, dans les provinces, l'administration devrait être confiée à une commission indépendante, sans caractère politique, responsable au lieutenant-gouverneur-en-conseil, soit directement, soit par l'intermédiaire du Service de la Santé. A la rigueur, le Plan pourrait fonctionner sous l'autorité du Service de la Santé, pourvu que les organismes responsables des services hospitaliers aient leur part d'influence dans le contrôle et l'administration desdits services.

**13. Représentation des hôpitaux dans la Commission.**

La Commission, nombreuse ou peu nombreuse, devrait être largement représentative des divers groupes concernés, c'est-à-dire, de ceux qui reçoivent des services et de ceux qui en rendent. Quand la Commission est petite, le représentant des hôpitaux n'est pas payé; si la Commission est importante, il serait rémunéré. C'est à cause de l'importance que prennent les services des hôpitaux, sous un plan quelconque d'assurance-maladie, que les hôpitaux devraient avoir leur propre représentant à cette Commission.

On présume que le plan pourvoira à la formation d'un conseil consultatif ou d'un bureau dont l'objet sera d'aviser la Commission (ou le service de santé) en rapport avec les opération en cours. L'organisation officielle de l'hôpital, du gouvernement provincial et fédéral, suivant le cas, devrait y être représentée.

On recommande qu'un comité consultatif soit attaché

au conseil d'administration du Plan où le Conseil des Hôpitaux du Canada aurait ses représentants.

**14. Le fonds d'assurance-maladie devrait être sous forme de contributions.**

Il est grandement désirable que l'assurance-maladie soit établie sur une base de contributions. Bien que, en dernière analyse, les dettes sociales soient acquittées par les individus, il vaut mieux que chaque citoyen ait le sentiment de sa responsabilité personnelle et qu'il contribue directement au maintien de l'assurance-maladie.

Dans notre opinion, le fonds de l'assurance-maladie devrait être constitué par des contributions (a) des assurés, (b) des employeurs, (c) du gouvernement fédéral, (d) du gouvernement provincial.

## Récommandations Générales

**15. La médecine préventive, facteur primordial.**

La médecine préventive est tellement nécessaire au bien-être de la nation qu'elle doit surtout attirer l'attention des législateurs. Toute dépense publique faite en vue d'améliorer la santé générale ou de prévenir les maladies rapporte en santé et en prospérité nationales mille fois plus que la dépense elle-même. C'est pourquoi, il devrait y avoir coopération et coordination d'effort entre les corps dirigeants du fédéral et du provincial, entre le service fédéral et provincial de la Santé.

**16. Recherche.**

Tout plan devrait affecter un fonds de réserve à la conduite de recherches scientifiques. La médecine scientifique n'est pas stagnante. L'amélioration actuelle de la santé en général est due aux recherches de nos prédécesseurs. Bien plus, notre pays a profité des recherches des autres pays. Il est bien équitable maintenant que le Canada apporte sa juste contribution au progrès scientifique.

**17. Les hôpitaux et l'enseignement.**

Il importe beaucoup que l'enseignement clinique soit maintenu dans les écoles de médecine. L'éducation médicale présuppose le recours à l'enseignement théorique et à la clinique donnée au lit du malade. Il se pourrait que l'enseignement clinique s'altérât sous l'empire d'un plan qui incluerait tous les individus, assurés ou non, à moins que le Plan ne protège cet enseignement par des conventions efficaces. Il y aurait baisse dans l'éducation médicale au Canada, si l'accession à la clinique diminuait; et les conséquences de cette baisse affecteraient la santé de la génération future. Les stipulations nécessaires au maintien de la clinique devraient être insérées dans des règlements provinciaux.

**18. On devrait encourager les hauts salariés à adopter le plan d'assurance-maladie dans les hôpitaux à charte indépendante.**

Si l'on établissait un niveau de revenu particulier, au-dessous duquel la participation à l'assurance-maladie serait obligatoire et au-dessus duquel elle serait impossible, il se trouverait un grand nombre d'individus et de familles à ne pas profiter de l'assurance-maladie. Pour cette catégorie, on recommande la cré-

ation de plans connexes au plan d'assurance-maladie, plans qui encourageraient l'utilisation des hôpitaux à charte indépendante, sans but lucratif, répandus à travers toute la province. Quand c'est possible, les plans en vigueur pourraient être modifiés de façon à s'adapter aux nouvelles conditions et les comités d'organisation de ces plans employés à cette fin, tout en se conformant évidemment à un standard raisonnable.

**19. Indemnités.**

Il est clair que, sous l'empire d'un plan quelconque d'assurance-maladie ou de sécurité sociale, l'octroi d'une indemnité à la famille du malade soit d'un grand secours. Actuellement, l'assurance-chômage n'accorde aucune indemnité à l'ouvrier contraint au chômage pour cause de maladie. Cependant, l'octroi d'indemnités complique la situation du médecin et de l'hôpital; d'autant plus que, sous le système des Compensations ouvrières et autres plans de secours semblables, les malades ont eu tendance à prolonger leur convalescence au-delà de la période nécessaire. Il en est résulté des ennuis pour l'hôpital et pour le médecin consciencieux.

Si l'on considère l'indemnité comme chose nécessaire, ce qui peut être le cas, il est recommandable qu'elle soit tirée d'un fonds distinct du fonds d'assurance-maladie.

**20. Le secret professionnel.**

Il est manifeste que l'introduction d'un plan général d'assurance-maladie entraînera l'obligation de remplir de nombreux rapports au sujet de ces patients. Cela soulève une question d'éthique professionnelle spécifiant les circonstances qui justifient les hôpitaux, les médecins, les garde-malades de révèler des informations de nature essentiellement confidentielle. Un point médico-légal est ici en cause. Avant qu'aucune mesure ne soit mise en vigueur, il est fort à propos que l'on tire au clair la position des hôpitaux et de leur personnel, en ce qui concerne cette question du secret professionnel.

**Autres recommandations remises à plus tard.**

Il est bien possible, quand le projet rédigé sera mis à l'étude et que des développements nouveaux surgissent des discussions soulevées par et devant le Comité Spécial, que les représentants des hôpitaux désirent une nouvelle occasion de discuter certains détails concernant l'hospitalisation.

**Conclusion**

En conclusion, le Conseil des Hôpitaux du Canada, au nom des hôpitaux de ce pays, manifeste son désir d'apporter tout l'appui possible à l'élaboration d'un plan d'assurance-maladie qui procurera un secours permanent aux malades et tendra à l'amélioration de la santé nationale.

---

**Army wing added to Prince Albert Hospital**

Construction has begun on the military wing to be added to the Victoria Hospital at Prince Albert, Saskatchewan. This will have 60 beds. An army isolation unit is also under construction.

# Correspondence

### Insurance Report Charges

*To the Editor,*

Dear Sir: A large motor manufacturing firm has just informed us through their Moncton manager that their insurance carriers have complained that this is the only hospital in Canada which charges to prepare abstracts and reports for insurance companies and beneficiaries and those on sick benefits. We have made a charge of $2 since 1932, when a resolution to that effect was adopted at our provincial meeting.

Complimented as I feel at being pointed out as something unique in hospital business administration, I am curious to know if all the staunch assertions that hosptials were justified in making this nominal fee have fallen by the wayside and that hospitals generally were waiving this practice.

Will you ask for comments in your next issue?

*Yours very sincerely,*

Ruth C. Wilson,
Secretary,
The Moncton Hospital.

I believe that the practice varies, but that a good many hospitals feel justified in making a charge for the filling out of forms for companies that operate upon a commercial basis. We would appreciate, however, hearing from our readers. Ed.

* * * *

### Nurses' Uniforms

*To the Editor,*

Dear Sir: We are informed by the maker of our hospital uniforms that no cotton can be used on cotton. When it comes to making nurses' bodicies this is not a success, as the under-arm portion must frequently be replaced. He is of the opinion that the double bodice has 40 per cent. more wearing value than the single ply, as well as being more sightly in appearance, and asks permission to revert to the old type.

Have you had any other complaints on this subject?

*Yours truly,*

George F. Stephens, M.D.
Superintendent, Royal Victoria Hospital, Montreal.

What do other hospitals think of this suggestion? Should it be taken up with the Cotton Controller? Ed.

---

#### "Actions Speak Louder——"

A very generous "thank you" is being tendered the residents of St. Lawrence, Newfoundland, and vicinity for their "heroic services to the men of the U.S. Navy" when they were instrumental in saving most of the crews of the wrecked U.S. destroyers Pollux and Truxton. The American Senate naval affairs committee has authorized the building of a $50,000 hospital at St. Lawrence.

# Book Reviews

FIRST AID MANUAL — Prepared by the Canadian Red Cross Society. Pp. 163, illust. Toronto, 1943.

This manual on first aid is an excellent addition to the available literature on the subject. It will be of value not only for wartime emergencies but for ordinary civilian needs. In addition to the care of injuries, resuscitation and kindred topics, there are chapters also on poisons, on the removal of foreign bodies and on the cause and treatment of insensibility. There is also an appendix dealing with first aid measures related to air-raid precautions. The illustrations are particularly helpful.

* * *

DICTIONARY OF BIOCHEMISTRY AND RELATED SUBJECTS—Edited by William M. Malisoff, Professor of Biochemistry, Polytechnic Institute of Brooklyn, and twenty-two collaborators, representative of the leading laboratories in the United States. Pp. 579, illustrated with charts. Price $7.50. Philosophical Library Inc., New York. 1943.

This volume by a lengthy list of collaborators is "a pioneering effort in an entirely new field." It is more than a dictionary of terms, as considerable explanatory material is included with many of the items.

It is not a manual of working methods, as the details of procedures are not given, but it would prove of great assistance to students of biochemical literature who desire an explanation of the many terms used and who require orientation with respect to the many proper terms used in describing tests. In many respects it is an abbreviated encyclopaedia.

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OPERATING ROOM TECHNIQUE — By Edythe Louise Alexander, R.N., Supervisor of the Operating Rooms of the Roosevelt Hospital, New York City. Pp. 392, illust. Price $4.50. The C. V. Mosby Co., St. Louis, Mo. Canadian Agents, McAinish & Co., Ltd., Toronto. 1943.

This is an excellent review of operating room technique from the viewpoint of the nursing staff. The material is well arranged and particularly well set up for quick reference. The numerous illustrations are very helpful in the further exposition of the text. Emphasis is laid upon the equipment and the order of procedure. This book can be highly recommended.

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CANADA, 1943—Published by authority of the Hon. James A. McKinnon, Minister of Trade and Commerce. Pp. 196, illustrated. Price twenty-five cents. King's Printer, Ottawa. 1943.

This official handbook is a concise and popular summary of the more exhaustive **Canada Year Book.** Profusely illustrated, it gives statistical tables and graphs relating to every aspect of Canadian life. Copies of this booklet should be in every hospital and medical library and in every nurses' residence.

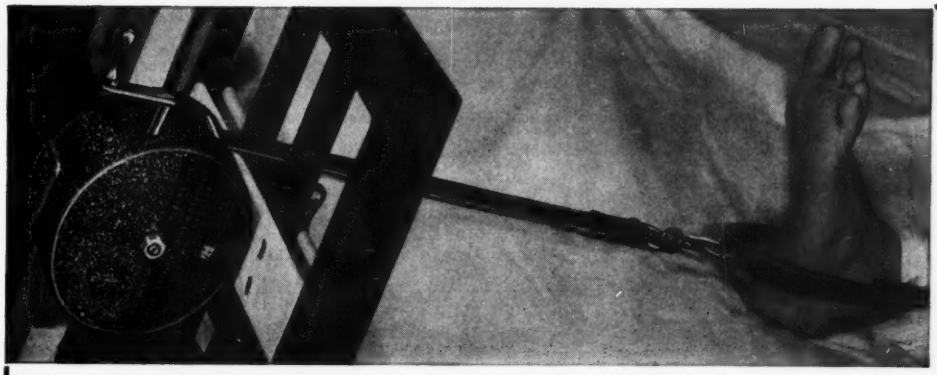
**National Health Survey**

*(Continued from page 16)*

tary and civilian needs. The army is supposed to have one dentist to 500 establishment; actually it has one to 699. The ratio for civilians is but 1 to 3,477. It was recommended that dental technicians be considered as in an essential industry and that dental nurses be not permitted to change occupations unless proven to be in the national interest. Dentists should be immobilized unless with the approval of the Dental Advisory Board.

**Medical Schools**

Between 20 and 25 per cent. of teachers are now enlisted. Any further enlistment of medical teachers may prove serious to medical teaching. Before more teachers be taken they should be replaced by colleagues who have served for some time in the Armed Forces. The medical output must be increased to meet needs of health insurance. This will be very expensive, especially when it comes to enlarging or developing laboratories. More medical schools may be needed.



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**Cancer Control**

*(Continued from page 17)*

4. The Federal and Provincial Governments should allow no financial, geographic or other obstacles to exist which might prevent any person from receiving early and efficient treatment.

5. A model plan for the management of cancer should be approved and incorporated either in the Health Insurance Section of the Bill, or in the regulations governing the administration of the bill under the titles of Standards and Conditions, in Paragraph 4 of the Federal portion of the draft.

**Recommendations**

With regard to such a plan, the Committee wishes to make the following recommendations:

1. That cancer be made a reportable disease, such report to be made to the properly constituted authority of the Province, and to include the means whereby the diagnosis had been made.

2. That adequate provisions be made for the statistical analysis of cancer data.

3. That the Provincial Health Insurance Commission establish an organization for the purpose of correlating all cancer activities and of receiving and analyzing reports and data, and that the office of the medical statistician be attached thereto.

4. That this organization should include a representative named by each of the following: Each Medical School of the Province; the Provincial Medical Association or Associations; the Department of Health of the Province; and subsequently by each of the Cancer Treatment Centres approved by the above-named representatives.

*Functions of Provincial Organization*

The general functions of such an organization to be appointed by the Provincial Health Insurance Commission should be as follows:

(a) To advise as to the organization of diagnostic and treatment centres for cancer and the personnel thereof;

(b) To assist these centres in the treatment of cancer by means of funds, radium and equipment;

(c) To arrange through the Provincial Health Insurance Commission provision for clinics and other diagnostic facilities, including the outlying districts;

(d) To receive grants, gifts and

## COMING CONVENTIONS

June 12-14—Catholic Hospital Association of the United States and Canada, William Penn Hotel, Pittsburgh, Pa.

June14-15—Canadian Medical Association (General Council only), Montreal, Que.

June 29-30—Maritime Hospital Association, Kentville, N.S.

September 9-10—Canadian Hospital Council, Chateau Laurier, Ottawa.

September 13-17—American Hospital Association, Buffalo, N.Y.

October 20-22—Ontario Hospital Association, Royal York Hotel, Toronto.

bequests, and to administer all funds received;

(e) To concern itself with the problems of the transportation of patients who live at a distance from a treatment centre;

(f) To participate in a program for the education of the medical and nursing professions, education of the public being developed in collaboration with the Canadian Society for the Control of Cancer;

(g) To foster rearch in cancer, more particularly in respect to clinical and technical problems;

(h) To ensure that suitable facilities are provided for (1) convalescent hospitals, and (2) hospitals for incurables, the number, size and location of these to be determined by the individual province;

(i) That under the Regional Medical officer provided for in Section 44-3 (e) of the drafted Bill there should be personnel (social service, nursing or secretarial) whose duties it will be to obtain such information relative to cancer patients as might be required by the provincial organization on cancer, and in general to act in liaison between a cancer patient, his physician, and the central office or treatment centre;

(j) To be responsible for the organization of a bureau of investigation of alleged cancer cures. This might be operated as an activity of the Federal Government, somewhat along the lines of the existing arrangements for investigation under the Food and Drugs Act.

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**Hospitals in Britain**

*(Concluded from page 28)*

mention and that is the appointment in the larger hospitals of Welfare Supervisors to help the probationer in her adjustment to hospital life and to increase her cultural and social development and social well-being. Some more progressive Matrons point out that this is inconsistent with suggestions to give the nurses greater self-government and that the regulation of their social activities may well be left to their own discretion.

The publication of this proposal has been followed by the advertisement of a new appointment under the auspices of the Middlesex County Council, to be called "Health Registrar". The qualifications are denoted in the statement: "Applicants with training in social science or experience in industrial welfare work preferred." The whole-time duties will include "recording of incidence of sickness in various hospital departments, investigations of all absence for health reasons, inquiry into working conditions, home visits if necessary, etc.". It will be interesting to learn in due course how far this is to be interpreted as applying to nursing staff. It shows, however, the application of Dr. Bevington's reasoning that hospitals have something to learn from the methods adopted in industry. Whether that is altogether desirable is a matter upon which I may have more to say as soon as the committee under the chairmanship of Lord Rushcliffe has completed its reports.



## *Index of Advertisers*

### JUNE, 1943